

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3745

CERTIFICATE OF DEATH

Reg. Dist. No.

03617

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltersville</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>74 Beltersville</u>		d. STREET ADDRESS <u>4519 Powdermill Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4519 Powdermill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LAST FIRST Middle</u> <u>ABERNATHY, JOHN ALLEN</u>		4. DATE OF DEATH <u>March 18, 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1875</u>
9. AGE (In years last birthday) <u>84 yrs.</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motor Operator - Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Abernathy</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Beavers</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Emma Bernice Abernathy (Same as #2)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: <u>177X Metastatic Carcinoma</u> DUE TO <u>Carcinoma of the prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>approx 2 yrs</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-3</u> , 19 <u>60</u> , to <u>3-17</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-17</u> , 19 <u>60</u> , and that death occurred at <u>11:4</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. A. Purdie</u>		ADDRESS (Street, city or town, state) <u>4404 Greensburg Rd</u>	
PHYSICIAN'S NAME (Type) <u>D. A. PURDIE</u>		DATE SIGNED <u>Riverdale Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>March 21, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Colman Manor, Pa. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters, 254 Carroll Dr NW DC</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u>MAR 22 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. No. 10

1750

PLACE OF DEATH HOME		DECEASED NAME	
STREET NO. 1234		AGE 45	
CITY BALTIMORE		SEX MALE	
STATE MARYLAND		RACE WHITE	
DATE OF DEATH JAN 15 1918		TIME OF DEATH 10:30 AM	
PLACE OF BIRTH BALTIMORE		DATE OF BIRTH DEC 15 1872	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
MEDICAL HISTORY NONE		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF CORONER (None)	
SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03618

3668

1. PLACE OF DEATH a. COUNTY Princ Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67 Greenbelt	
c. LENGTH OF STAY IN 1b 58 Min		d. STREET ADDRESS 6 L Research Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Boy Middle Anthi Last Mar		4. DATE OF DEATH Month March Day 2 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 2, 1960
9. AGE (In years lost birthday) 68		10. IF UNDER 1 YEAR Months — Days — Hours —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Anthi		14. MOTHER'S MAIDEN NAME Carrol Ann Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mother	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis 770.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Erythroblastosis Fetalis (Rh incompatibility) DUE TO (c) From birth		INTERVAL BETWEEN ONSET AND DEATH from birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 2, 1960 to Mar. 2, 1960 that I last saw the deceased alive on Mar. 2, 1960 , and that death occurred at 9 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Hans Wodak		ADDRESS (Street, city, or town, state) 90 E Parkway, Greenbelt, Md.	
PHYSICIAN'S NAME (Type) Dr. Hans Wodak, M. D.		DATE SIGNED 3-4-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 3/7/60	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr		24a. REC'D BY REGISTRAR DATE MAR 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Krantz			

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03619

3669

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARY Dis. of Columbia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5019 Just Street N.E.			
3. NAME OF DECEASED (Type or print) First Robert Middle Carroll Last Barr				4. DATE OF DEATH Month March Day 20 Year 19 60			
5. SEX Male		6. COLOR OR RACE col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 11-16-35		9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 24 Days 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman		10b. KIND OF BUSINESS OR INDUSTRY Metropolitan Police		11. BIRTHPLACE (State or foreign country) Florida			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Robert Lee Barr			
14. MOTHER'S MAIDEN NAME Katie Bacon				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes			
16. SOCIAL SECURITY NO. 1954-58		17. INFORMANT Ann Duncan Barr; same address as # 2.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock DUE TO 816X Conditions, if any, which gave rise to immediate cause (b) Bilateral rupture of lungs due to crushed chest, (c) fractured pelvis, laceration of l. Subclavian Art.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Operator of an automobile in collision with another auto.					
20c. TIME OF INJURY Month, Day, Year Hour 11:30 p. m. 3-19-1960		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway			
20f. (City or town) Kennelworth		(County) Pr. Geo. Md. (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED March 20, 1960					
EXAMINER'S NAME (Type) John T. Maloney, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-25-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat Cemetery			
22d. LOCATION (City, town, or county) Arlington		(State) Va.					
23. FUNERAL DIRECTOR'S SIGNATURE MORROW + Woodford		ADDRESS 1122 St. NW		24a. REC'D BY REGISTRAR MAR 22 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Knead							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
JAMES J. JONES

AGE
45

SEX
Male

DATE OF DEATH
1911

RESIDENCE
Boston

DATE OF BIRTH
1866

PLACE OF BIRTH
Ireland

CAUSE OF DEATH
Heart Disease

PLACE OF DEATH
Home

TIME OF DEATH
10:00 AM

SEX
Male

AGE
45

DATE OF BIRTH
1866

PLACE OF BIRTH
Ireland

CAUSE OF DEATH
Heart Disease

PLACE OF DEATH
Home

DATE OF DEATH
1911

RESIDENCE
Boston

DATE OF DEATH
1911

PLACE OF DEATH
Home

SEX
Male

AGE
45

DATE OF BIRTH
1866

PLACE OF BIRTH
Ireland

CAUSE OF DEATH
Heart Disease

PLACE OF DEATH
Home

Signature of Medical Examiner
JAMES J. JONES

Signature of Registrar
JAMES J. JONES

Signature of Coroner
JAMES J. JONES

Signature of Jury
JAMES J. JONES

Signature of Witnesses
JAMES J. JONES

Signature of Deceased
JAMES J. JONES

Signature of Family
JAMES J. JONES

Signature of Others
JAMES J. JONES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03620

3670

1. PLACE OF DEATH a. COUNTY Prince Georges County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C (Wash., 22) b. COUNTY PG	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md.		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Washington 22,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 7003 Allentown Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William		Middle E		Last Barrett	
4. DATE OF DEATH Month March		Day 11		Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/1/83		9. AGE (In years lost birthday) 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) W.Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME H. Preston Barrett		14. MOTHER'S MAIDEN NAME Maggie Hawkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-30-2364		INFORMANT Loy W. Barrett, 7003 Allentown Rd., Wash. 22, D.C.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) A. S. H. D., CHF, (c) Uremia		INTERVAL BETWEEN ONSET AND DEATH		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Mar. 3, 19 60, to Mar. 11, 19 60 that I last saw the deceased alive on Mar. 11, 19 60, and that death occurred at 9:05 PM, from the causes and on the date stated above.					
ACTUAL SIGNATURE David S. Clayman M.D.		ADDRESS (Street, city or town, state) 6311 Baltimore Ave.		DATE SIGNED 3/12/60	
PHYSICIAN'S NAME (Type) DR. David S. Clayman, M.D.		Riverdale, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/60		22c. NAME OF CEMETERY OR CREMATORY Everett Cemetery	
22d. LOCATION (City, town, or county) Everett		(State) Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE Cherry E. Jones		ADDRESS 5103 W. 11th St. Wash. D.C.		24a. REC'D BY REGISTRAR DATE MAR 16 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Evans					

CERTIFICATE OF DEATH

3830

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3730
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

03621

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b <u>6 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 4th Street</u>				d. STREET ADDRESS <u>31 4th St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>M.</u> Last <u>Buttley</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 7/1882</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Thomas Switzer</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Beckett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Mrs Lester Lerie Laurel Md.</u> Address <u>31 4th St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Devericulis</u> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pyelonephritis</u> DUE TO (c) <u>Chronic Myocarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Myocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 wk.</u> <u>13 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/20 1960</u> to <u>3/22 1960</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>B. P. Warren</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>B. P. WARREN</u>				22d. ADDRESS <u>Laurel Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>March 25, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ing Hill Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Reuben S. Searleson, Laurel, Md</u> ADDRESS				25a. REC'D BY REGISTRAR <u>DATE MAR 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

3730

11-11-11

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VS A15 (4)
ISM 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3747

CERTIFICATE OF DEATH

03623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Hghts.		c. LENGTH OF STAY IN 1b 9 mons.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5302--Clark Pl., SE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGNES Middle H. Last BOWIE		4. DATE OF DEATH Month Mar. Day 23 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 29th 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Chroniger		14. MOTHER'S MAIDEN NAME Mary Jane Johnstone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
INFORMANT Ruth Evans		Address 5302--Clark Pl., SE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO 4 yr. (c)			INTERVAL BETWEEN ONSET AND DEATH 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 3-19, 1960 , to 3:23 , 1960, that I last saw the deceased alive on 3-19, 1960 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE: Frank S. Pellegrini		ADDRESS (Street, city or town, state) 3409--Alabama Ave., SE Wash. DC	
PHYSICIAN'S NAME (Type) Frank S. Pellegrini Dr.		DATE SIGNED 3-23-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Southland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ammons Bros.		24a. REC'D BY REGISTRAR 1661--Good Hope Rd. SE WASH. 20 20	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris		DATE MAR 28 '60	

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3672

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 41 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince Georges		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		d. STREET ADDRESS 1 Rt.3 Box 257		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Maggie		First Maggie		Middle Bowling		Last Bowling		4. DATE OF DEATH Month March 10		Day 10		Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 6 1887		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY and				11. BIRTHPLACE (State or foreign country) and				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Take Holland				14. MOTHER'S MAIDEN NAME Nancy Watson Westwood mcl											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)				INFORMANT Nancy Watson Westwood mcl				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema secondary to multiple emboli. 442x DUE TO Multiple pulmonary infarcts, bilaterally. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral thrombosis DUE TO Hypertensive arteriosclerotic cardiovascular-renal disease (c) years.												INTERVAL BETWEEN ONSET AND DEATH 24 hours. 24 hours. 1 month.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Jan. 29, 1960 to March 10, 1960 , that I last saw the deceased alive on March 10, 1960 , and that death occurred at 9:05 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Saved S. Clayman				ADDRESS (Street, city or town, state) 6311 Beets Ave. Rockville, Md 20850				DATE SIGNED 3/11/60							
PHYSICIAN'S NAME (Type) George H. Nelson				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-14-60				22c. NAME OF CEMETERY OR CREMATORY St. Thomas			
23. FUNERAL DIRECTOR'S SIGNATURE George H. Nelson				ADDRESS Cyprus				24a. REC'D BY REGISTRAR Mar 14 '60				24b. REGISTRAR'S SIGNATURE William E. Frank			

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Handwritten notes and calculations, including a table with columns for 'Date', 'Description', and 'Amount'. The text is mirrored and difficult to read.

Handwritten notes and calculations, including a table with columns for 'Date', 'Description', and 'Amount'. The text is mirrored and difficult to read.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3748

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03625

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheltenham</u>				c. LENGTH OF STAY IN 1b <u>3 months</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Frank Juppert Road</u>				d. STREET ADDRESS <u>Frank Juppert Rd</u>			
3. NAME OF DECEASED (Type or print) <u>Glenn Noel Bryan</u>				4. DATE OF DEATH <u>March 31 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 25, 1959</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR <u>3</u> Months <u>6</u> Days		IF UNDER 24 HRS. <u>Hours</u> <u>Min.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Bryan</u>				14. MOTHER'S MAIDEN NAME <u>Jennette Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>493X</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				DATE SIGNED <u>3-31-60</u>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>March 31, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Aumam Funeral Home</u>		22d. LOCATION (City, town, or county) (State) <u>Reading, Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W-W Chambers Co 5801 Cleveland Ave Riverdale Md</u>				24a. REC'D BY REGISTRAR <u>APR 4 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Rouse</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3749

CERTIFICATE OF DEATH

Reg. Dist. No.

03626

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D C b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS 624.Randolph. st N W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA A BURNS First Middle Last				4. DATE OF DEATH March 25 19 60 Month Day Year			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3.17.1878	
				9. AGE (In years lost birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret D C.				10b. KIND OF BUSINESS OR INDUSTRY Health Dept		11. BIRTHPLACE (State or foreign country) Washington D C.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Robert P. Burns				14. MOTHER'S MAIDEN NAME Mary. Bowen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Address Robert C. Burns 6500 Hemlock.Pl.S E.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Myocardial Infarction</i> DUE TO (c) <i>Generalized Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Recent In Spindrome</i> INTERVAL BETWEEN ONSET AND DEATH <i>Yes</i> <i>Yes</i>							
18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959, 19, to March 25, 1960, that I last saw the deceased alive on 3/25/60, 1960, and that death occurred at 1:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE T. F. O. DONOVAN M.D. 2811 PA AVE SE WASH PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3.28.1960		22c. NAME OF CEMETERY OR CREMATORY Mt.Olivet.Cemetery		22d. LOCATION (City, town, or county) (State) Washington D C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee.Funeral Home 300.4th st N E.				24a. REC'D BY REGISTRAR MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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1923

CERTIFICATE OF DEATH

3742

George

D.C.

Washington

England

British Hoteling Home

624 Randolph St. N.W.

60

March 22

BURNS

ANNA

White

7.1878

Washington D.C.

British Hoteling Home

Mary, House

Robert F. Burns

Robert C. Burns 5500 Nemick St. N.W.

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be retained by the hospital or attending physician.
FURNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3750
CERTIFICATE OF DEATH

Reg. Dist. No.

03627

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
f. STREET ADDRESS 2322 Branch Ave S.E.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle E. Last BURNS				4. DATE OF DEATH Month March Day 20 Year 1960			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-18-74	
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none			
11. BIRTHPLACE (State or foreign country) D.C.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Pettis				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) I				16. SOCIAL SECURITY NO. Evelyn Swann - 2322 - Branch Ave. S.E.			
17. INFORMANT Evelyn Swann - 2322 - Branch Ave. S.E.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1953 to Mar 20 , 19 60 , that I last saw the deceased alive on Mar 19 , 19 60 , and that death occurred at 2:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3112 Ala Ave S.E. D.C. 20 DATE SIGNED ACTUAL SIGNATURE J. H. Thibodeau M.D. PHYSICIAN'S NAME (Type) D. C. 20							
22a. BURIAL, CREMATION, or other disposition (Specify) Burial				22b. DATE THEREOF 3-23-60			
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill				22d. LOCATION (City, town, or county) (State) Suitland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				ADDRESS			
24a. REC'D BY REGISTRAR DATE MAR 22 '60				24b. REGISTRAR'S SIGNATURE Cirving L. Thoms			

1988

CERTIFICATE OF DEATH

3750



Prison Records

D.C.

Washington

Washington

Englewood Hotel, Room

2322 East 14th St. S.E.

MARY

WHITE

March 20, 1900

2-18-74

M

W

E

none

D.C.

D.C.

Unborn

Possibly

John Smith - 1900 - Brown

Handwritten signature

March 1, 1900

Washington, D.C.

For General Files - Washington, D.C.

3665

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>18th Rainier</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4602-29th street</u>		d. STREET ADDRESS <u>4602-29th street</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine A Cavanaugh</u>		4. DATE OF DEATH <u>March 3rd 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>	
11. BIRTHPLACE (State or foreign country) <u>Wyoming, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Mosier</u>		14. MOTHER'S MAIDEN NAME <u>Sophia ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Frances Cavanaugh, Daughter</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral heart failure</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>10 1/2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/22</u> , 19 <u>49</u> , to <u>3/3</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u>2/27</u> , 19 <u>60</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard J. Walsh</u>		ADDRESS (Street, city or town, state) <u>900-17th St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD J. WALSH</u>		DATE SIGNED <u>3/4/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) <u>Silver Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 8 '60</u>	
ADDRESS <u>Mt. Rainier, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

3673

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY		PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 10 hours 10 years 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 1, 1952, to April 19, 1960, that I last saw the deceased alive on April 19, 1960, and that death occurred at 6:15 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED					
ACTUAL SIGNATURE		WILLIAM BRAININ M.D.		6124 Central Ave		3/19/60			
PHYSICIAN'S NAME (Type)		WM BRAININ		Capitol Bldg Md					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
Burial		3-23-60		Epiphany Church		Forestville.Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
J. W. L. L. L.		300 4th St NW		DATE MAR 22 '60					

TQ HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
ISM 9/58



3623

DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3674 Item 8 Film G258 3/11/60 lwk
CERTIFICATE OF DEATH

Reg. Dist. No.

03630

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				d. STREET ADDRESS 5150 Auth St S.E.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Henson		First J.		Last Chase		4. DATE OF DEATH Month Mar Day 3 Year 1960	
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 27, 1873	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Govt. Employee-Retired Laborer				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME David Chase				14. MOTHER'S MAIDEN NAME Millie Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 21538 5097			
INFORMANT Inez C. Williams				Address 5150 Auth Rd., Springs			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebrovascular accident (hemorrhage) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 11 days DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb. 21 , 19 60 to Mar. 3 , 19 60 that I last saw the deceased alive on Mar. 3 , 19 60 , and that death occurred at 10:20AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 940 25th St. N.W. Washington, 27 D.C. DATE SIGNED Mar 7 '60							
ACTUAL SIGNATURE Jeannette C. Bateman				M.D. 940 25th St. N.W. Washington, 27 D.C.			
PHYSICIAN'S NAME (Type) Jeannette C. Bateman, M.D.				Jeannette C. Bateman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-6-60		22c. NAME OF CEMETERY OR CREMATORY Union Bethel	
22d. LOCATION (City, town, or county) (State) T.B. Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Myrtle R. Rollins				ADDRESS 4339 Hunt Pl. N.E.		24a. REC'D BY REGISTRAR MAR 7 '60	
24b. REGISTRAR'S SIGNATURE Carlton L. Howard							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the Deputy Medical Examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the Deputy Medical Examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the Deputy Medical Examiner or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03631

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> by COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>13 OXON HILL</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hosp</u>				e. STREET ADDRESS <u>'83 20 Old Fort Road</u>			
3. NAME OF DECEASED (Type or print) <u>KATRINA</u>		First Middle Last		4. DATE OF DEATH <u>March 23 1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb 2, 1960</u>	9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS HACKNER</u>				14. MOTHER'S MAIDEN NAME <u>FLORINE ELIZABETH CLARK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If give war or dates of service)</u>		17. INFORMANT <u>Florine E. Clark, home #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3-25-60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>National Harmony</u>				22d. LOCATION (City, town, or country) (State) <u>prince Georges County, Md.</u>			
23. FUNERAL DIRECTOR <u>John T. Rhines & Company</u>				24a. REC'D BY REGISTRAR <u>24b. REGISTRAR'S SIGNATURE</u>			
ADDRESS <u>3015 - 12th St., N.E. Washington 17, D. C.</u>				DATE <u>MAR 28 '60</u>			

VS. A15ME
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3727 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7208 Halleck Street</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> d. STREET ADDRESS <u>7208 Halleck Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Michael Alan Clark</u> First Middle Last				4. DATE OF DEATH <u>March 4 1960</u> Month Day Year											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 25, 1939</u>		9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>University, Maryland</u>				11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Percy Ellsworth Clark</u>						14. MOTHER'S MAIDEN NAME <u>Alma Atkins</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>213-38-0800</u>				17. INFORMANT <u>Percy E Clark</u> Address <u>same as #2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun shot wound of chest</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was found in bed room shot through chest</u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>3-4 1960</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>District Heights</u> (County) <u>PG</u> (State) <u>MD</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/>															
ACTUAL SIGNATURE <u>James I. Boyd</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 4, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>March 7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>				22d. LOCATION (City, town, or county) <u>Southland, Maryland</u> (State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u> ADDRESS <u>1661-gd Hoped</u>						24a. REC'D BY REGISTRAR <u>March 7 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3757 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
9. OCCUPATION		10. MARITAL STATUS		11. EDUCATION		12. RELIGION		13. PREVIOUS ILLNESS		14. CAUSE OF DEATH		15. MANNER OF DEATH		16. SIGNATURE OF EXAMINER	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE		22. SIGNATURE OF CLERK		23. SIGNATURE OF SHERIFF		24. SIGNATURE OF DEPUTY SHERIFF	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3751 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03633

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville			c. LENGTH OF STAY IN 1b 5 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 W. Hyattsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6603 Karlson Court				d. STREET ADDRESS 6603 Karlson Court.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Francis Middle Everett Last Cole				4. DATE OF DEATH Month March Day 14 Year 19 60			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-5-98	
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	
10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Dist. of Columbia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Elmer M. Cole				14. MOTHER'S MAIDEN NAME Susie Kinslow			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-574909		17. INFORMANT Address Charles M. Cole; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED March 14, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3.16.1960		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Lee. Funeral Home ADDRESS 300.4th st N E				24a. REC'D BY REGISTRAR DATE MAR 16 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hance	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>CHAS. COUNTY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SOUTHERN MARYLAND HOSP. CENTER</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SARAH</u> Middle <u>COLLINS</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>3</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/83</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES HENRY GRAY</u>		14. MOTHER'S MAIDEN NAME <u>EMMA JOSEPHINE GRAY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EMMA CLARK</u>		Address <u>LA PLATA MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>HYPER TENSIVE ARTERIOSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 HOUR</u> <u>4 YRS</u> <u>4 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/1</u> , 19 <u>54</u> , to <u>3/25</u> , 19 <u>60</u> that I last saw the deceased alive on <u>3/25</u> , 19 <u>60</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred R. Lapin</u> M.D.		ADDRESS (Street, city or town, state) <u>501 MD HOSPITAL CTR</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ALFRED R. LAPIN, M.D.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>3/29/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>McCarrie</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson & Furber</u> ADDRESS <u>4801 N. YAW</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 29 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3732

RECEIVED

U. S. DEPARTMENT OF HEALTH - LABOR AND WELFARE

3753

CERTIFICATE OF DEATH

Reg. Dist. No.

03635

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE P.G. b. COUNTY P.G. (DISTRICT OF COLUMBIA)			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 38 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 WASHINGTON, D.C. (RURAL)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 6964 ALLENTOWN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GLORIA Middle MARTHA Last CONLEY		4. DATE OF DEATH Month MARCH Day 27 Year 1960					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 MARCH 1937	9. AGE (In years lost birthday) yrs. 23	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK-TYPIST		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ROY TRAVIS			14. MOTHER'S MAIDEN NAME BESSIE POOVY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO		INFORMANT Address HUSBAND SAME AS 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACUTE RENAL FAILURE DUE TO (c) ACUTE INFECTIOUS HEPATITIS							INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 6 DAYS 6 WEEKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 FEB , 19 60 , to 27 MAR , 19 60 , that I last saw the deceased alive on 27 MARCH , 19 60 , and that death occurred at 10:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Sidney B. Kern		ADDRESS (Street, city or town, state) ANDREWS AIR FORCE BASE		DATE SIGNED 27 MARCH 60			
PHYSICIAN'S NAME (Type) SIDNEY B. KERN, MAJ, USAF, MC		USAF HOSPITAL ANDREWS, WASHINGTON 25, DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-30-60		22c. NAME OF CEMETERY OR CREMATORY Morganton North Carolina		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Russell Funeral Home 816 Hst. NE. DC 2				24a. REC'D BY REGISTRAR DATE MAR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

[Handwritten signature or initials at the bottom left.]

[Handwritten text at the bottom right:]
Final burial time 8:45 PM

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3676 Item 13 FilmG261 4-19-60 et
CERTIFICATE OF DEATH

03636

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucinda Middle L. Last Conley				4. DATE OF DEATH Month March Day 27 Year 19 60			
5. SEX Female		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-28-1918	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months 41 Days 41 Hours 41 Min.		IF UNDER 24 HRS. Months 41 Days 41 Hours 41 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator				10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Alabama	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME William London				14. MOTHER'S MAIDEN NAME Josephine King			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. INFORMANT			
Address Carrington Conley 512 62nd PL. Seat Pleasant							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hepatic coma DUE TO (c) Carcinoma of liver							
INTERVAL BETWEEN ONSET AND DEATH 2 days 9 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 25 1960 to March 27 1960 that I last saw the deceased alive on March 27 1960 , and that death occurred at 9:41 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE J. S. Clague				ADDRESS (Street, city or town, state) 6311 Brookland, Riverdale, Md DATE SIGNED 3/27/60			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-31-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Va	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Sluway ADDRESS 30-H St.				24a. REC'D BY REGISTRAR APR 1 '60		24b. REGISTRAR'S SIGNATURE Charles E. Tucker	

MEDICAL CERTIFICATION

2

077

1

OFFICE OF THE SECRETARY OF DEFENSE

3870



1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

3754

CERTIFICATE OF DEATH

Reg. Dist. No.

03637

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA		b. COUNTY P.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 13 HRS 5 MIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 6152 WESTCHESTER DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NEWBORN TWIN "A"		First CULLEN		Last CULLEN		4. DATE OF DEATH Month MARCH Day 25 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 MARCH 1960		9. AGE (In years lost birthday) yrs. 13	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME ROBERT I CULLEN				14. MOTHER'S MAIDEN NAME ANNE B WILLOUGHBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) N/A		INFORMANT HOSPITAL CHART		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO PREMATURETY Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) DUE TO (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 13 HRS 5 MIN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 24 MARCH, 19 60, to 25 MARCH, 19 60, that I last saw the deceased alive on 25 MARCH, 19 60, and that death occurred at 12:40 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE [Signature]		M.D. USAF HOSPITAL ANDREWS					
PHYSICIAN'S NAME (Type) SALVADORE BATTIATA CAPT USAF MC		ANDREWS AIR FORCE BASE WASHINGTON 25, DC					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-29-60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		22d. LOCATION (City, town, or county) (State) ARLINGTON VA.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Kinalth Funeral Home Inc. 816 N. St. N.E. DC 2				24a. REC'D BY REGISTRAR DATE MAR 29 '60		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2150365XVI

1080-1

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

0752

Blank certificate form with faint horizontal lines and a large rectangular box in the center.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3755

CERTIFICATE OF DEATH

Reg. Dist. No.

03638

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY (DISTRICT OF COLUMBIA) PG			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN lb 13 HRS 36 MIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 1 6152 WESTCHESTER DRIVE		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NEWBORN TWIN "B" CULLEN				4. DATE OF DEATH Month Day Year MARCH 25 19 60			
5. SEX FEMALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 MARCH 1960	
9. AGE (In years last birthday) yrs.		10. AGE (In years last birthday) yrs.		11. IF UNDER 1 YEAR Months Days		12. IF UNDER 24 HRS. Hours Min 13 36	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? UNITED STATES							
13. FATHER'S NAME ROBERT I CULLEN				14. MOTHER'S MAIDEN NAME ANNE B WILLOUGHBY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. N/A		INFORMANT Address HOSPITAL CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURETY 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 13 HRS 36 MIN							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 24 MARCH, 19 60, to 25 MARCH, 19 60, that I last saw the deceased alive on 25 MARCH, 19 60, and that death occurred at 1:19 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE [Signature] USAF HOSPITAL ANDREWS PHYSICIAN'S NAME (Type) SALVADORE BATTIATA CAPT USAF MC ANDREWS AIR FORCE BASE WASHINGTON 25, DC							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3-29-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS [Signature] 816 H St. NE. DC 2				24a. REC'D BY REGISTRAR DATE MAR 29 '60		24b. REGISTRAR'S SIGNATURE [Signature]	

2250365XV1

1000

CERTIFICATE OF DEATH

3752

WOMAN 42

WOMAN 42

DATE

TIME

PLACE

Cause

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

STATE OF MARYLAND
3735
Item 8 Film 6258 3-14-60 et
CERTIFICATE OF DEATH

03639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b 26 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 9030 49th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Marian Middle B. Last Currey		4. DATE OF DEATH Month March Day 3 Year 1960		5. SEX female		6. COLOR OR RACE cauc.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1879 April 8, 1879		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min. 1960	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Michigan				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME James Patterson						14. MOTHER'S MAIDEN NAME Catherine Burns									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. None				17. INFORMANT Hospital Records.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Dis. DUE TO (c) General arteriosclerosis												INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 yrs 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 1959 to Mar 3 1960 , that I last saw the deceased alive on Mar 3 1960 , and that death occurred at 10:52 A.M. from the causes and on the date stated above.															
ACTUAL SIGNATURE L.W. Malin						ADDRESS (Street, city or town, state) Riverdale, Md						DATE SIGNED 3-3-60			
PHYSICIAN'S NAME (Type) L.W. Malin, M.D. 1404 Queensbury Rd., Riverdale, Maryland															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/7/60				22c. NAME OF CEMETERY OR INTERMENT PLACE George Washington				22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons						4739 Baltimore Avenue Hyattsville, Maryland				24a. REC'D BY REGISTRAR DATE MAR 7 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marlboro Pike				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George R. Curtin				4. DATE OF DEATH Month Day Year March 13, 19 60.			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 7, 1878	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (If not working, state last one) Carpenter - Farming				10b. KIND OF BUSINESS OR INDUSTRY Own Farm - Self-Employd Carp.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME James Baker Curtin				14. MOTHER'S MAIDEN NAME Elizabeth Kidwell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -- --			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12 Mar, 1960, to 13 Mar, 1960, that I last saw the deceased alive on 12 Mar, 1960, and that death occurred at 9:35 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Upper Marlboro, Md. 3/13/60 ACTUAL SIGNATURE R.B. Sasscer M.D. PHYSICIAN'S NAME (Type) Robert B. Sasscer, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/16/60		22c. NAME OF CEMETERY OR CREMATORY Rosaryville Cath. Cem.		22d. LOCATION (City, town, or county) (State) Rosaryville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR DATE MAR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

375



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

NAME: _____

DATE: _____

LOCATION: _____

CAUSE OF DEATH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

NAME OF DECEASED: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

NAME OF FATHER: _____

NAME OF MOTHER: _____

NAME OF SPOUSE: _____

NAME OF CHILDREN: _____

NAME OF NEXT OF KIN: _____

NAME OF PHYSICIAN: _____

NAME OF BURIAL PLACE: _____

NAME OF FUNERAL HOME: _____

NAME OF MINISTER: _____

NAME OF CLERGYMAN: _____

NAME OF CHURCH: _____

NAME OF CEMETERY: _____

NAME OF INTERVIEWER: _____

NAME OF WITNESS: _____

NAME OF SIGNER: _____

NAME OF OFFICIAL: _____

NAME OF JUDGE: _____

NAME OF CLERK: _____

NAME OF RECORDER: _____

NAME OF ARCHIVER: _____

NAME OF INDEXER: _____

NAME OF FILE CLERK: _____

NAME OF ASSISTANT: _____

NAME OF CLERICAL: _____

NAME OF ADMINISTRATIVE: _____

NAME OF SUPPORT: _____

NAME OF OTHER: _____

Reg. Dist. No.

3677

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook d. STREET ADDRESS 9404 Worrell Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Boy Dickens		4. DATE OF DEATH Month March Day 31 Year 19 60	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-30-60	
9. AGE (In years last birthday) yrs. 2 1/2		10. IF UNDER 1 YEAR Months 2 1/2 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NO		12. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME Harry		14. MOTHER'S MAIDEN NAME Jean E. Dowell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 776X DUE TO (c) 776X		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-30-60 , 19____, to 3-31-60 , 19____, that I last saw the deceased alive on 3-30-60 , 19 60 , and that death occurred at IA M, from the causes and on the date stated above ADDRESS (Street, city or town, state) 4410 74th Ave DATE SIGNED 4/1/60 ACTUAL SIGNATURE F. E. Musser, M.D. M.D. F. E. Musser, M.D. PHYSICIAN'S NAME (Type) F. E. Musser, M.D. London Hills, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/6/60	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr. ADDRESS Administrator.		24a. REC'D BY REGISTRAR DATE APR 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Knecht		24c. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
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3678

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS Brandywine Rt. 3 Box 332			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Mary Middle E. Last Diggs		4. DATE OF DEATH		Month Mar. Day 1 Year 19 60	
5. SEX F.	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-70		9. AGE (In years lost birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) none		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME none				14. MOTHER'S MAIDEN NAME none			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT		Address Gladys Diggs Brandywine Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho Pneumonia 455X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) San Juan Rt 700 DUE TO (c) none				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 29 , 19 60 , to Mar 1 , 19 60 , that I last saw the deceased alive on Mar. 1 , 19 60 , and that death occurred at M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE D. S. Clayman M.D.				ADDRESS (Street, city or town, state) 6311 Coatesville Road hq		DATE SIGNED 3/2/60	
PHYSICIAN'S NAME (Type) Dr. D.S. Clayman							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-60		22c. NAME OF CEMETERY OR CREMATORY Brandywine Md		22d. LOCATION (City, town, or county) (State) Brandywine Md	
23. FUNERAL DIRECTOR'S SIGNATURE George L. Nelson ADDRESS Aguasscond				24a. REC'D BY REGISTRAR Mar 3 50 DATE		24b. REGISTRAR'S SIGNATURE Arthur S. Kane	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3679

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rogers Heights 39			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5006 55th. Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DENNIS Middle ANDREW Last DIXON				4. DATE OF DEATH Month March Day 25th Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 May 1889		9. AGE (In years exact birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Self		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin F. Dixon				14. MOTHER'S MAIDEN NAME Susanna Phipps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-26-5375		17. INFORMANT Minnie M. Dixon (Wife)		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (c) Cardiovascular renal disease (a), stating the underlying cause lost. DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 28, 1960		22c. NAME OF CEMETERY Fort Lincoln		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.				24a. REC'D BY REGISTRAR MAR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JURY		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY		19. SIGNATURE OF JURY		20. SIGNATURE OF JURY	
21. SIGNATURE OF JURY		22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY		25. SIGNATURE OF JURY	
26. SIGNATURE OF JURY		27. SIGNATURE OF JURY		28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY		34. SIGNATURE OF JURY		35. SIGNATURE OF JURY	
36. SIGNATURE OF JURY		37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY		40. SIGNATURE OF JURY	
41. SIGNATURE OF JURY		42. SIGNATURE OF JURY		43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY		49. SIGNATURE OF JURY		50. SIGNATURE OF JURY	
51. SIGNATURE OF JURY		52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY		55. SIGNATURE OF JURY	
56. SIGNATURE OF JURY		57. SIGNATURE OF JURY		58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY		64. SIGNATURE OF JURY		65. SIGNATURE OF JURY	
66. SIGNATURE OF JURY		67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY		70. SIGNATURE OF JURY	
71. SIGNATURE OF JURY		72. SIGNATURE OF JURY		73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY		79. SIGNATURE OF JURY		80. SIGNATURE OF JURY	
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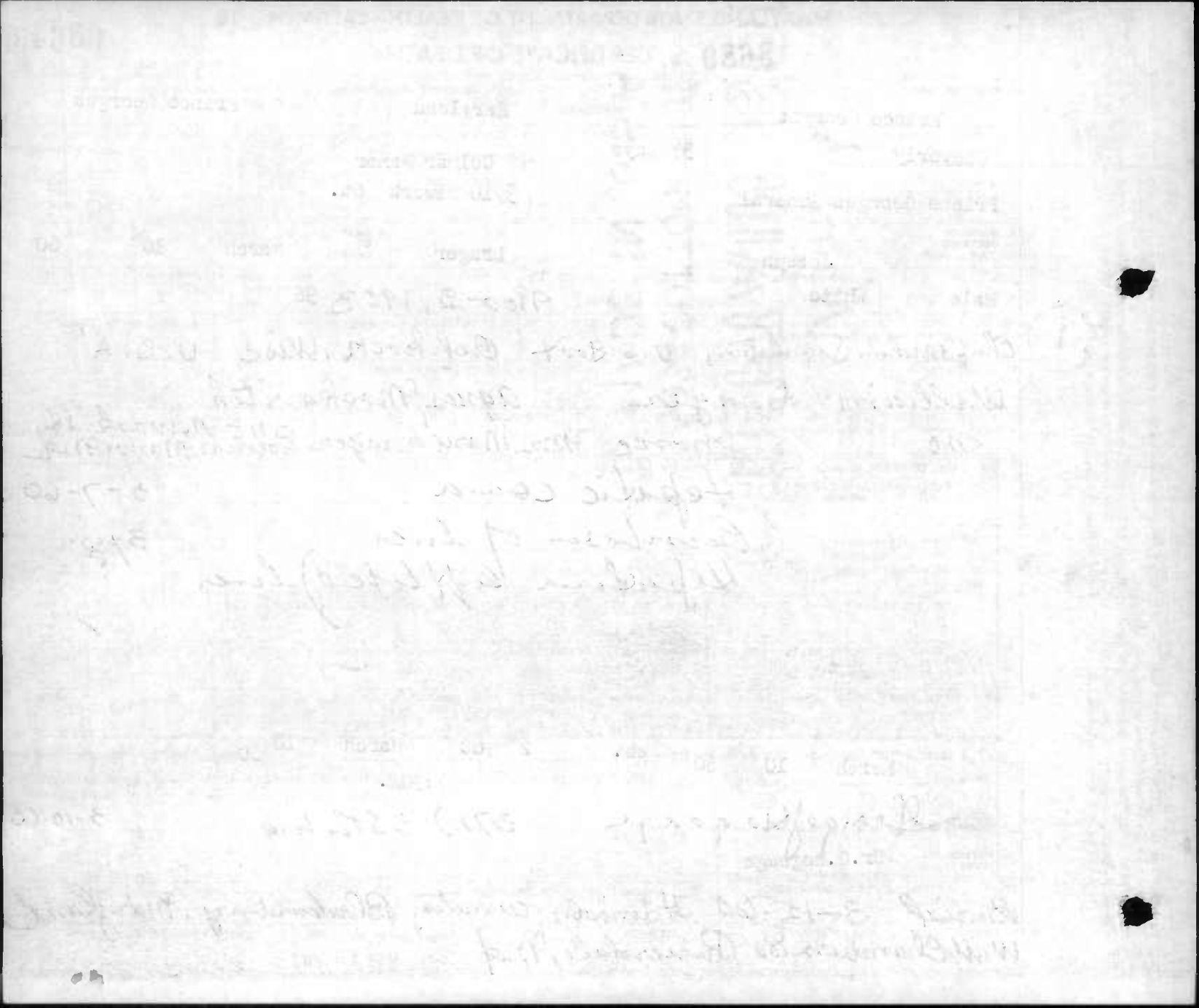
CERTIFICATE OF DEATH

Reg. Dist. No.

03643

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 37 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle Drager Last Drager				4. DATE OF DEATH Month March Day 10 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov-2, 1903	
9. AGE (In years not birthday) 56 yrs.		IF UNDER 1 YEAR Months 3 Days 10 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Machine Sabulation U.S. Govt				10b. KIND OF BUSINESS OR INDUSTRY Cashbook, Wisc.			
11. BIRTHPLACE (State or foreign country) U.S.A.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Drager				14. MOTHER'S MAIDEN NAME Agnes Moskavitch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Cirrhosis of liver DUE TO (c) Hepaticoma left lobe of liver				INTERVAL BETWEEN ONSET AND DEATH 3-7-60 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 2, 1960 , to March 10, 1960 , that I last saw the deceased alive on March 10, 1960 , and that death occurred at 7:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE George Hageage				ADDRESS (Street, city or town, state) 3712-38th Ave			
PHYSICIAN'S NAME (Type) Dr. G. Hageage				DATE SIGNED 3-10-60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-60		22c. NAME OF CEMETERY OR CREMATORY St. Michaels cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.M. Chambers & Co. Riverdale, Md				24a. REC'D BY REGISTRAR DATE MAR 14 '60			
				24b. REGISTRAR'S SIGNATURE Carl S. Kinn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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Office of the

Secretary of the

War Department

Washington, D.C.

Approved by the

Secretary of the

War Department

For the purpose of the

War Department

War Department

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Parkland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5405 Silver Hill Rd.				d. STREET ADDRESS 5405 Silver Hill Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle NMI Last Dyer		4. DATE OF DEATH Month Mar. Day 24 Year 1960					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 Jan. 1891	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Dyer				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *****		INFORMANT Elsie I. Dyer		Address 5405 Silver Hill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) General Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 9 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) natural Causes					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from March 15, 1960 to March 29, 1960 that I last saw the deceased alive on March 21, 1960 , and that death occurred at 6:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul C. Van Natta				ADDRESS (Street, city or town, state) 5440 Silver Hill Rd.			
PHYSICIAN'S NAME (Type) /Paul C. Van Natta				DATE SIGNED 5440 Silver Hill Rd.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/26/60		22c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		22d. LOCATION (City, town, or county) (State) Wash DC	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				ADDRESS 300-4th St. N. E. DC		24. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR MAR 28 '60 Arthur S. House	

124

3682

CERTIFICATE OF DEATH

03646

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 25 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Hyattsville Kent Village		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 2724 73rd Place/			
3. NAME OF DECEASED (Type or print) First Martin Middle H. Last Feigel				4. DATE OF DEATH Month March Day 12 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 June 1899	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Representenative Crest Mfg. Co.				10b. KIND OF BUSINESS OR INDUSTRY New York City		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Feigel				14. MOTHER'S MAIDEN NAME Josephine Helmken			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes 11/18-12/18		16. SOCIAL SECURITY NO. 090-05-5061		INFORMANT Address Frances Lillian Feigel same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163x Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Adenos. Carcinoma of Left Lung (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 7 month	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 14 March 1960 , 19 59 , to March 12, 1960 , that I last saw the deceased alive on 14 March 1960 , and that death occurred at 8:44 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7315 Landon Rd Hyattsville, Md DATE SIGNED 12 March 1960							
ACTUAL SIGNATURE Thos M. Hutchins		M.D. 7315 Landon Rd Hyattsville, Md					
PHYSICIAN'S NAME (Type) T. M. Hutchins							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 3/15/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		22d. LOCATION (City, town, or county) (State) Prince George, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thos S. Hines				ADDRESS 2901-14th St N.W.		24a. REC'D BY REGISTRAR MAR 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
VS A15 (4)
15M 9/58

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1

up

CERTIFICATE OF DEATH

3653

DECEASED
NAME
AGE
SEX
DATE OF BIRTH
PLACE OF BIRTH
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH
SIGNATURE OF REGISTRAR
OFFICE OF THE REGISTRAR

3758

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Suitland Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4733 Homer Ave. Suitland Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Theodora</u> Middle <u>North</u> Last <u>Filly</u>				4. DATE OF DEATH <u>MARCH 29 1960</u> Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 2, 1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Joseph B. North</u>				14. MOTHER'S MAIDEN NAME <u>MARY LEON HARDT</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Morrison DeArmond</u>				Address <u>4733 Homer Ave Suitland Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MESENTERIC THROMBOSIS-MASSIVE</u> <u>420.0</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Long standing Arteriosclerotic Heart disease</u> DUE TO (c) <u>Embolism from Atrial thrombus</u> INTERVAL BETWEEN ONSET AND DEATH <u>12-72 HRS.</u> <u>MANY YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atrial Fibrillation</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 1959</u> , to <u>MAR. 29, 1960</u> , that I last saw the deceased alive on <u>MAR 28</u> , 19 <u>60</u> , and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above. <u>3-29-60</u> ADDRESS (Street, city or town, state) <u>7200 Marlboro Pike, Wash 28, D.C.</u> DATE SIGNED <u>3/29/60</u>							
ACTUAL SIGNATURE <u>W.B. Sheer M.D.</u> M.D.				PHYSICIAN'S NAME (Type) <u>WALTER B. SHEER M.D.</u>			
22a. BURIAL, CREMATION, OR DISPOSAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>4/1/1960</u>		<u>ARLINGTON NATL</u>		<u>ARLINGTON VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. CHAMBERS Co - 517-1125156.</u> ADDRESS <u>WASH. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3736

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03648

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 University Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 4208 Colesville Road			
3. NAME OF DECEASED (Type or print) First Villa Middle E. Last Fisher				4. DATE OF DEATH Month March Day 13 Year 1960			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-85	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Michigan		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joe Harold				14. MOTHER'S MAIDEN NAME Lida Read Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records; Leland Memorial Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO 904.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of right hip with hip nailing operation. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall in home					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 3-1- 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) University Park Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 14, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) transportation 3/16/60		22b. DATE THEREOF 3/16/60		22c. NAME OF CEMETERY OR CREMATORY Orlando		22d. LOCATION (City, town, or county) (State) Florida	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR MAR 17 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to a funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

3683

CERTIFICATE OF DEATH

Reg. Dist. No.

03649

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. LENGTH OF STAY IN 1b 4 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Charles Last Fletcher				4. DATE OF DEATH Month March Day 17 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/22/86	
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Cab Driver				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Winchester, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Fletcher				14. MOTHER'S MAIDEN NAME Sarah Eaton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 574-22-8408			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary thrombosis (c) Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Mar. 14 , 19 60 , to Mar. 17 , 19 60 that I last saw the deceased alive on Mar. 17 , 19 60 , and that death occurred at 9:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE David S. Clayman				ADDRESS (Street, city or town, state) 6311 Falls Ave - Riverdale, Md.			
PHYSICIAN'S NAME (Type) DAVID S. CLAYMAN				DATE SIGNED 3/18/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-60		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Winchester, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co				ADDRESS Riverdale, Md.		24a. REC'D BY REGISTRAR MAR 21 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3683

3683

Office of the
County Clerk
County of
State of
Date
Received of
the sum of
Dollars
for
the purpose of
paying
the
of
the
County of
State of

to the
County Clerk
for the purpose of
paying
the
of
the
County of
State of
the sum of
Dollars
for
the purpose of
paying
the
of
the
County of
State of

Witness my hand and seal
this 1st day of
1900
County Clerk
State of

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3759
CERTIFICATE OF DEATH

Reg. Dist. No.

03650

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>		c. LENGTH OF STAY IN 1b <u>18 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>2610 K. St., N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cleothas</u> <u>-</u> <u>Floyd</u>				4. DATE OF DEATH Month Day Year <u>3</u> <u>22</u> <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>year 1892 ?</u>		9. AGE (In years lost birthday) <u>68 ? yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Mullins, S. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sandy Floyd</u>				14. MOTHER'S MAIDEN NAME <u>Virginia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>-</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		INFORMANT <u>Lizzie Carr (sister)</u>		Address <u>915 Willow Rd. Greensboro, N.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subacute monocytic leukemia</u> <u>204.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/4</u> , 19 <u>60</u> , to <u>3/22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/22</u> , 19 <u>60</u> , and that death occurred at <u>3:10 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale Hospital</u> <u>3/22/60</u> PHYSICIAN'S NAME (Type) <u>Moe Weiss, M.D.</u> <u>Glenn Dale, Md.</u>							
22a. BURIAL, CREMATION, (REMOVAL) (Specify) <u>3/23/60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>?</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro, North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Fogies Funeral Home Inc-389 Rd Ave</u>				24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10000

3750



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3726 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **4839**

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor		c. LENGTH OF STAY IN lb transient		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Bladensburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4103 Lawrence Street				d. STREET ADDRESS 4105 51st. Street			
3. NAME OF DECEASED (Type or print) First Maxine Middle Lorraine Last Gibson				4. DATE OF DEATH Month March Day 30 Year 19 60			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-14-27		9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book-keeper		10b. KIND OF BUSINESS OR INDUSTRY Refrigeration		11. BIRTHPLACE (State or foreign country) W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Guy Adams				14. MOTHER'S MAIDEN NAME ✓			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 236-32-6010		17. INFORMANT James Hubert Gibson; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 981X DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound of head (c) 981X DUE TO (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot in the head by another person with a .32 cal. bullet					
20c. TIME OF INJURY Hour 8.00 p. m. Month, Day, Year 3-30-60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Am. Legion Home		20f. (City or town) Colmar Manor		(County) Pr. Geo.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney		EXAMINER'S NAME (Type) John T. Maloney, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED April 1, 1960	
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 4, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE APR 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEATH NO. COUNTY CITY DISTRICT		DEATH NO. COUNTY CITY DISTRICT	
NAME OF DECEASED SEX AGE OCCUPATION		NAME OF DECEASED SEX AGE OCCUPATION	
PLACE OF DEATH TIME OF DEATH CAUSE OF DEATH		PLACE OF DEATH TIME OF DEATH CAUSE OF DEATH	
SIGNATURE OF EXAMINER DATE		SIGNATURE OF EXAMINER DATE	

3684

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS 23 District Heights 7606 Kipling Parkway			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Julia Middle ELIZABETH Last Gorrick				4. DATE OF DEATH Month March Day 10 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-8-83	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.		IF UNDER 24 HRS. Months 76 Days 76 Hours 76 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME MICHAEL SUGHRUE				14. MOTHER'S MAIDEN NAME CATHERINE MURPHY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE UNKNOWN			
17. INFORMANT HELEN H. HATTIS				Address 7606 KIPLING PARKWAY DISTRICT HEIGHTS, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade - Rupture of Left Ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction due to coronary Thrombosis (c) Revascularized - Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 11 hours 3-4 days 15 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Mellitus - 20 yrs.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 10 1960 to March 10 1960 , that I last saw the deceased alive on March 10 1960 , and that death occurred at 12:20 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE William Brainin M.D.				ADDRESS (Street, city or town, state) 6124 Central Ave 3/10/60			
PHYSICIAN'S NAME (Type) WM BRAININ				DATE SIGNED 3/10/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/14/60			
22c. NAME OF CEMETERY OR CREMATORY mt. Olivet				22d. LOCATION (City, town, or county) (State) Washington DC			
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Es. 517 11th St SE				ADDRESS 517 11th St SE			
24a. REC'D BY REGISTRAR MAR 14 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Haus			

3884

1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 3685 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03652

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 24			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. STREET ADDRESS 6600 Walker Mill Road							
3. NAME OF DECEASED (Type or print) James Courtney Gray				4. DATE OF DEATH March 27, 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter				10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 577-22-0583			
17. INFORMANT Mrs Edith Gray, same as # 2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James I. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) March 28, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 31, 1960		22c. NAME OF CEMETERY OR CREMATORY Epithany Cemetery		22d. LOCATION (City, town, or country) (State) Forestville, Maryland.	
23. FUNERAL DIRECTOR W. W. CHAMBERS CO., Riverdale, Md.				24a. REC'D BY REGISTRAR MAR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

MEDICAL CERTIFICATION

3883

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03653

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN lb <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Contee</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>Van Dusen Road</u>			
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>ALFREDA</u> Last <u>GRAY</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 Aug 1954</u>		9. AGE (In years last birthday) <u>5</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John A. Gray</u>				14. MOTHER'S MAIDEN NAME <u>Ruth A. Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John A. Gray (Father)</u> Address <u>Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>2nd, 3rd and 4th degree burns of 85% Of body</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Clothing caught fire at burning trash pile.</u>					
20c. TIME OF INJURY Month, Day, Year <u>3-23- 19 60</u> Hour <u>3:45</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Yard</u>		20f. (City or town) (County) (State) <u>Contee Pr. Geo. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-26-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mir Kirk</u>		22d. LOCATION (City, town, or county) (State) <u>Mir Kirk, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>			

MEDICAL CERTIFICATION

16

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3760 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03654

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. LENGTH OF STAY IN lb <u>Dead on arrival</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dobson Clinic</u>				d. STREET ADDRESS <u>Route # 3, Box 49</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>T</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 8/09</u>		9. AGE (In years last birthday) <u>51</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sam Green</u>				14. MOTHER'S MAIDEN NAME <u>Betty Orffield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Mrs Jane Green, same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u></p> <p><u>420.1</u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div style="width: 60%;"> <p>(b) <u>Cardiovascular renal disease</u></p> <p>DUE TO</p> <p>(c)</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>				DATE SIGNED <u>March 7, 1960</u>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				DEPUTY MEDICAL EXAMINER <u>xxx</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>3-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Memorial Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 9 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Christina A. Hanna</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. STANDARD MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED LAST, FIRST, MIDDLE (Print or type name in full)		2. PLACE OF BIRTH (Print or type name of place)	
3. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		4. RACE (Print or type name of race)	
5. DATE OF DEATH (Print or type date)		6. TIME OF DEATH (Print or type time)	
7. PLACE OF DEATH (Print or type name of place)		8. NAME OF PHYSICIAN (Print or type name)	
9. NAME OF HOSPITAL (Print or type name)		10. NAME OF NURSE (Print or type name)	
11. NAME OF FUNERAL HOME (Print or type name)		12. NAME OF BURIAL PLACE (Print or type name)	
13. NAME OF CEMETERY (Print or type name)		14. NAME OF INTERMENT (Print or type name)	
15. NAME OF CREMATOR (Print or type name)		16. NAME OF CREMATION (Print or type name)	
17. NAME OF REINTERMENT (Print or type name)		18. NAME OF REINTERMENT (Print or type name)	
19. NAME OF REINTERMENT (Print or type name)		20. NAME OF REINTERMENT (Print or type name)	
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99. NAME OF REINTERMENT (Print or type name)		100. NAME OF REINTERMENT (Print or type name)	

3687

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland by COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Carter Green Middle X Last X		4. DATE OF DEATH Month Mar. Day 30 Year 1960	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1960
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3 Days 22 Hours 21 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Solomon Troy		14. MOTHER'S MAIDEN NAME Dorothy Green	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Atelantasi Pneumonia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20e. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 26 , 19 60 , to Mar. 30 , 19 60 , that I last saw the deceased alive on Mar. 30 , 19 60 , and that death occurred at 8:25 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville 3/31/60 DATE SIGNED	
PHYSICIAN'S NAME (Type or print) Dr. John W. Perkins M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/6/60	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W Penn, Jr., Administrator.		24a. REC'D BY REGISTRAR DATE APR 11 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Knecht			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
3761
CERTIFICATE OF DEATH

03655

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEST HYATTSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5701- 33rd. AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle L Last GREENSTREET				4. DATE OF DEATH Month 3 Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/31/86	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk of Government of Belgium				10b. KIND OF BUSINESS OR INDUSTRY Belgium			
13. FATHER'S NAME William Temple Greenstreet				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Nannie B. Greenstreet Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Failure 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized Carcinomatosis DUE TO (c) Carcinoma of the Lungs						INTERVAL BETWEEN ONSET AND DEATH 3 days 1 mo 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 1957 to Mar 11, 1960 , that (I) (we) last saw the deceased alive on 3/10 19 60 , and that death occurred at 6:30 AM, from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Trozzo, Jr.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/11/60	
22c. PHYSICIAN'S NAME (Type) Frank M. Trozzo, Jr.				22d. ADDRESS 3501 Hamilton St. Hyte Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 3/14/60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington 9, D.C.		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	
				DATE MAR 14 '60			

10000

CERTIFICATE OF DEATH

1981

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03656

3762

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 2 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON DC 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 219-12th St, NE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last OTELIA (NMI) GURLEY				4. DATE OF DEATH Month Day Year MARCH 21 19 60			
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 25 MARCH 1907		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME BENJAMIN GLOVER				14. MOTHER'S MAIDEN NAME OTELIA GLOVER (MADISON)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) N/A		INFORMANT SON		Address SAME AS ITEM 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CIRRHOSIS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS 1-2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 MARCH, 1960, to 21 MARCH, 1960, that I last saw the deceased alive on 21 MARCH, 1960, and that death occurred at 2:40 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED J. Carroll Ramseyer M.D. USAF HOSPITAL ANDREWS 21 MARCH 1960 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) J CARROLL RAMSEYER, CAPT, USAF, MC ANDREWS AFB WASHINGTON 25 DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE B. F. Taylor				ADDRESS 909 6th St N.W. D.C.		24a. REC'D BY REGISTRAR DATE MAR 24 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Time of death: _____

8. Cause of death: _____

9. Place of death: _____

10. Signature of attending physician: _____

11. Signature of medical examiner: _____

12. Signature of coroner: _____

13. Signature of registrar: _____

14. Signature of informant: _____

15. Signature of witness: _____

16. Signature of funeral director: _____

17. Signature of undertaker: _____

18. Signature of cemetery: _____

19. Signature of burial place: _____

20. Signature of interment: _____

21. Signature of cremation: _____

22. Signature of other: _____

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3763 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03657

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crofton</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Waldorf</u>		d. STREET ADDRESS <u>Route #5</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 67 - Crofton, Md</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anthony Burch Guyman</u>				4. DATE OF DEATH Month Day Year <u>March 25 1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1912</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. &</u>	
13. FATHER'S NAME <u>Francis Bernard Guyman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Lola Burch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>976 X</u>		17. INFORMANT <u>Joseph Edwin Guyman same as #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun shot wound of head</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self through head</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>6:00</u> <u>am</u> <u>3-24</u> <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Front of home Crofton P.S. Md</u>		20f. (City or town) (County) (State) <u>Waldorf Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Notural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James I. Boyd</u>		EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-25-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 29 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hunt</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH—BALTIMORE 12

77 2191 01 0001

2010-08-08 10:00 AM

3737 CERTIFICATE OF DEATH

Reg. Dist. No.

P3658

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>01 Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Belend Memorial Hosp</u>		d. STREET ADDRESS <u>1800 Fairlawn Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary Elizabeth</u> Middle <u>Hazelton</u> Last <u>Hazelton</u>		4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6 1880</u> yrs. <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Russell</u>		14. MOTHER'S MAIDEN NAME <u>Lilly Gradman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Hosp. Records</u>		Address <u>_____</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>420.0</u> DUE TO <u>Constrictive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASAD</u> (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u> <u>3 da</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-4-</u> , 19 <u>60</u> to <u>3-5-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-5-</u> , 19 <u>60</u> , and that death occurred at <u>12:35A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>_____</u> DATE SIGNED <u>_____</u>			
ACTUAL SIGNATURE <u>Reynolds</u> M.D.			
PHYSICIAN'S NAME (Type) <u>_____</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>March 8, 1960</u>	<u>Gate of Heaven</u>	<u>Silver Spring Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>De Witt Randolph</u>		<u>Laurel, Md</u>	<u>Arthur S. Kenna</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3661

CERTIFICATE OF DEATH

Reg. Dist. No.

03659

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> <u>APOTHECARY</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Washington DC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>SAINT BRANCH NURSING HOME</u>		d. STREET ADDRESS <u>2502-14th NE apt 252A</u>	
3. NAME OF DECEASED (Type or print) First <u>SAUL</u> Middle <u>HELMAN</u> Last <u>HELMAN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-23-1900</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>39</u> Days <u>39</u> Hours <u>39</u> Min. <u>39</u>	IF UNDER 24 HRS. Months <u>39</u> Days <u>39</u> Hours <u>39</u> Min. <u>39</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FORKIER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RUSSIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HARRY HELMAN</u>		14. MOTHER'S MAIDEN NAME <u>EVA LESSNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-07-0714</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of rectum with</u> <u>154X</u> DUE TO <u>Generalized metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized metastases</u> DUE TO (c) <u>Generalized metastases</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>54</u> , to <u>March 26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 23</u> , 19 <u>60</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Saul Holzman</u>		ADDRESS (Street, city or town, state) <u>900 17th A. NW Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>Saul Holzman</u>		DATE SIGNED <u>Mar 28 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NAT'L. MEM. PARK</u>	22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Greeneberg Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Mar 28 '60</u>	
ADDRESS <u>4217-92nd St NW</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-11-2010 BY 60322 UCBAW/DK

CERTIFICATE OF DEATH

Reg. Dist. No.

3764

03660

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE (DISTRICT OF COLUMBIA) b. COUNTY P.B.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE		c. LENGTH OF STAY IN 1b 9 HRS 19 MIN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 20 WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 3111 PARKWAY TERRACE DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GEOFFREY ARNOLD HELTON				4. DATE OF DEATH Month Day Year MARCH 10 19 60			
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 MARCH 1960		9. AGE (In years last birthday) yrs. 9	IF UNDER 1 YEAR Months Days 19	IF UNDER 24 HRS. Hours Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME DAN W HELTON				14. MOTHER'S MAIDEN NAME RITSUKO BEPPU			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE		INFORMANT FATHER		Address SAME AS ABOVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPHYXIATION 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ATELECTASIS, ETIOLOGY UNDETERMINED DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 HR 2 HRS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 MARCH, 19 60, to 10 MARCH, 19 60, that I last saw the deceased alive on 10 MARCH, 19 60, and that death occurred at 6:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Stanley M. Sinkford M.D. USAF HOSPITAL ANDREWS 10 MARCH 60 PHYSICIAN'S NAME (Type) STANLEY M SINKFORD, CAPT USAF MC ANDREWS AIR FORCE BASE, WASHINGTON 25, DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-14-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY PUBLIC CREMATION		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR DATE MAR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

How 4/10/60

2050272XV4

CORONER'S OFFICE D.C.

MAR 10 4 33 PM '60

RECEIVED

U.S. DEPARTMENT OF JUSTICE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03661

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Beaver Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hoapital				d. STREET ADDRESS 1 1510 49th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Almstard Last Holbert				4. DATE OF DEATH Month March Day 17 Year 19 60			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-7-07	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac Kinney				14. MOTHER'S MAIDEN NAME Florence Hunter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Frances Holbert; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 527.1 IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Bronchial asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Severe emphysema and Cor pulmonale PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 0 p. m. 0	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
3-20-60		3-20-60		Ebenezer Church Cem		White Post Va	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington				24a. REC'D BY REGISTRAR 4925 Adams Ave NE		24b. REGISTRAR'S SIGNATURE March 22 '60	

MEDICAL CERTIFICATION

2

2

3688 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

UNIVERSITY STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>10-15-1918</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Immediate cause: <u>Myocardial Infarction</u></p>		<p>8. Underlying cause: <u>Arteriosclerosis</u></p>	
<p>9. Contributing cause: <u>None</u></p>		<p>10. Manner of death: <u>Natural</u></p>	
<p>11. Signature of Examiner: <u>[Signature]</u></p>		<p>12. Signature of Physician: <u>[Signature]</u></p>	
<p>13. Date of examination: <u>10-15-1918</u></p>		<p>14. Time of examination: <u>10:00 AM</u></p>	
<p>15. Address of deceased: <u>123 Main St, Baltimore, Md.</u></p>		<p>16. Name of informant: <u>John J. Smith</u></p>	
<p>17. Relationship of informant: <u>Self</u></p>		<p>18. Name of physician: <u>Dr. J. H. Jones</u></p>	
<p>19. Name of hospital: <u>None</u></p>		<p>20. Name of funeral home: <u>None</u></p>	
<p>21. Name of undertaker: <u>None</u></p>		<p>22. Name of cemetery: <u>None</u></p>	
<p>23. Name of burial place: <u>None</u></p>		<p>24. Name of interment place: <u>None</u></p>	
<p>25. Name of crematorium: <u>None</u></p>		<p>26. Name of crematorium: <u>None</u></p>	
<p>27. Name of crematorium: <u>None</u></p>		<p>28. Name of crematorium: <u>None</u></p>	
<p>29. Name of crematorium: <u>None</u></p>		<p>30. Name of crematorium: <u>None</u></p>	
<p>31. Name of crematorium: <u>None</u></p>		<p>32. Name of crematorium: <u>None</u></p>	
<p>33. Name of crematorium: <u>None</u></p>		<p>34. Name of crematorium: <u>None</u></p>	
<p>35. Name of crematorium: <u>None</u></p>		<p>36. Name of crematorium: <u>None</u></p>	
<p>37. Name of crematorium: <u>None</u></p>		<p>38. Name of crematorium: <u>None</u></p>	
<p>39. Name of crematorium: <u>None</u></p>		<p>40. Name of crematorium: <u>None</u></p>	
<p>41. Name of crematorium: <u>None</u></p>		<p>42. Name of crematorium: <u>None</u></p>	
<p>43. Name of crematorium: <u>None</u></p>		<p>44. Name of crematorium: <u>None</u></p>	
<p>45. Name of crematorium: <u>None</u></p>		<p>46. Name of crematorium: <u>None</u></p>	
<p>47. Name of crematorium: <u>None</u></p>		<p>48. Name of crematorium: <u>None</u></p>	
<p>49. Name of crematorium: <u>None</u></p>		<p>50. Name of crematorium: <u>None</u></p>	
<p>51. Name of crematorium: <u>None</u></p>		<p>52. Name of crematorium: <u>None</u></p>	
<p>53. Name of crematorium: <u>None</u></p>		<p>54. Name of crematorium: <u>None</u></p>	
<p>55. Name of crematorium: <u>None</u></p>		<p>56. Name of crematorium: <u>None</u></p>	
<p>57. Name of crematorium: <u>None</u></p>		<p>58. Name of crematorium: <u>None</u></p>	
<p>59. Name of crematorium: <u>None</u></p>		<p>60. Name of crematorium: <u>None</u></p>	
<p>61. Name of crematorium: <u>None</u></p>		<p>62. Name of crematorium: <u>None</u></p>	
<p>63. Name of crematorium: <u>None</u></p>		<p>64. Name of crematorium: <u>None</u></p>	
<p>65. Name of crematorium: <u>None</u></p>		<p>66. Name of crematorium: <u>None</u></p>	
<p>67. Name of crematorium: <u>None</u></p>		<p>68. Name of crematorium: <u>None</u></p>	
<p>69. Name of crematorium: <u>None</u></p>		<p>70. Name of crematorium: <u>None</u></p>	
<p>71. Name of crematorium: <u>None</u></p>		<p>72. Name of crematorium: <u>None</u></p>	
<p>73. Name of crematorium: <u>None</u></p>		<p>74. Name of crematorium: <u>None</u></p>	
<p>75. Name of crematorium: <u>None</u></p>		<p>76. Name of crematorium: <u>None</u></p>	
<p>77. Name of crematorium: <u>None</u></p>		<p>78. Name of crematorium: <u>None</u></p>	
<p>79. Name of crematorium: <u>None</u></p>		<p>80. Name of crematorium: <u>None</u></p>	
<p>81. Name of crematorium: <u>None</u></p>		<p>82. Name of crematorium: <u>None</u></p>	
<p>83. Name of crematorium: <u>None</u></p>		<p>84. Name of crematorium: <u>None</u></p>	
<p>85. Name of crematorium: <u>None</u></p>		<p>86. Name of crematorium: <u>None</u></p>	
<p>87. Name of crematorium: <u>None</u></p>		<p>88. Name of crematorium: <u>None</u></p>	
<p>89. Name of crematorium: <u>None</u></p>		<p>90. Name of crematorium: <u>None</u></p>	
<p>91. Name of crematorium: <u>None</u></p>		<p>92. Name of crematorium: <u>None</u></p>	
<p>93. Name of crematorium: <u>None</u></p>		<p>94. Name of crematorium: <u>None</u></p>	
<p>95. Name of crematorium: <u>None</u></p>		<p>96. Name of crematorium: <u>None</u></p>	
<p>97. Name of crematorium: <u>None</u></p>		<p>98. Name of crematorium: <u>None</u></p>	
<p>99. Name of crematorium: <u>None</u></p>		<p>100. Name of crematorium: <u>None</u></p>	

3728

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forest Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15 Forest Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103-Iroquois Way S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle A. Last HORN		4. DATE OF DEATH Month March Day 4th. Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15th. 189D
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Gov.	11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Jessie Horn	
14. MOTHER'S MAIDEN NAME Elizabeth Schaffer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. WorldWar # 1.		17. INFORMANT Ruth I. Horn Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROSIS, GENERALIZED DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH Sudden year
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 58 , to March 4 , 19 60 , that I last saw the deceased alive on March 4 , 19 60 , and that death occurred at 1:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 101 Audrey Lane S.E. Glass Manor 3-4-60 DATE SIGNED ACTUAL SIGNATURE Herbert Wisotsky PHYSICIAN'S NAME (Type) 101--Audrey Lane S.E. Glass Manor, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF March 9-60	22c. NAME OF CEMETERY OR CREMATORY Gnaden Huettner Cemetery	22d. LOCATION (City, town, or county) (State) Lehighton, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Summers Brothers		24a. REC'D BY REGISTRAR DATE MAR 7 '60	24b. REGISTRAR'S SIGNATURE Arthur S. ...

1

Page 4

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3738 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04853
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 69 College Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital				d. STREET ADDRESS 9725 Narragansett Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Chris Middle Duane Last Hudson				4. DATE OF DEATH Month March Day 30 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 11, 1960		9. AGE (In years last birthday) 1 yrs.	IF UNDER 1 YEAR Months 1 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Gloria Hudson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Gloria Hudson; same address as # 2. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral edema and congestion DUE TO (c) Overdose of Tr. of opium.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Infant was given gtts. 2. of tr. of opium by physician doing					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 9.10 a.m. Mar. 30 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Doctor's office		20f. (City or town) (County) (State) Laurel Pr. Geo. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> March 31, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/2/60		22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md. ADDRESS				24a. REC'D BY REGISTRAR DATE APR 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2076191XV4

STATE OF MARYLAND—DEPARTMENT OF HEALTH—BALTIMORE 18

3689

CERTIFICATE OF DEATH

Reg. Dist. No.

03663

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 33 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Goerges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights d. STREET ADDRESS 731 59th. Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James E. Jackson				4. DATE OF DEATH Month Day Year March 6 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-8-78	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt		11. BIRTHPLACE (State or foreign country) Prince Geo County		12. CITIZEN OF WHAT COUNTRY? U. S A	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple pulmonary infarctions 466X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Pulmonary embolus DUE TO (c) Thrombosis, right common iliac vein							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Atherosclerotic heart disease ② Multiple duodenal ulcers							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Feb. 2, 19 60 to March 6, 19 60 , that I last saw the deceased alive on March 6, 19 60 , and that death occurred at 1:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE D. S. Clayman				ADDRESS (Street, city or town, state) 6311 Belts Ave. Riverdale Md			
DATE SIGNED 3/7/60							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
3-11-60		3-11-60		mt Olivet		Washington DC	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Washington				ADDRESS 4925 Deane Ave NE		24a. REC'D BY REGISTRAR DATE MAR 14 60	
				24b. REGISTRAR'S SIGNATURE Arthur S. [illegible]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

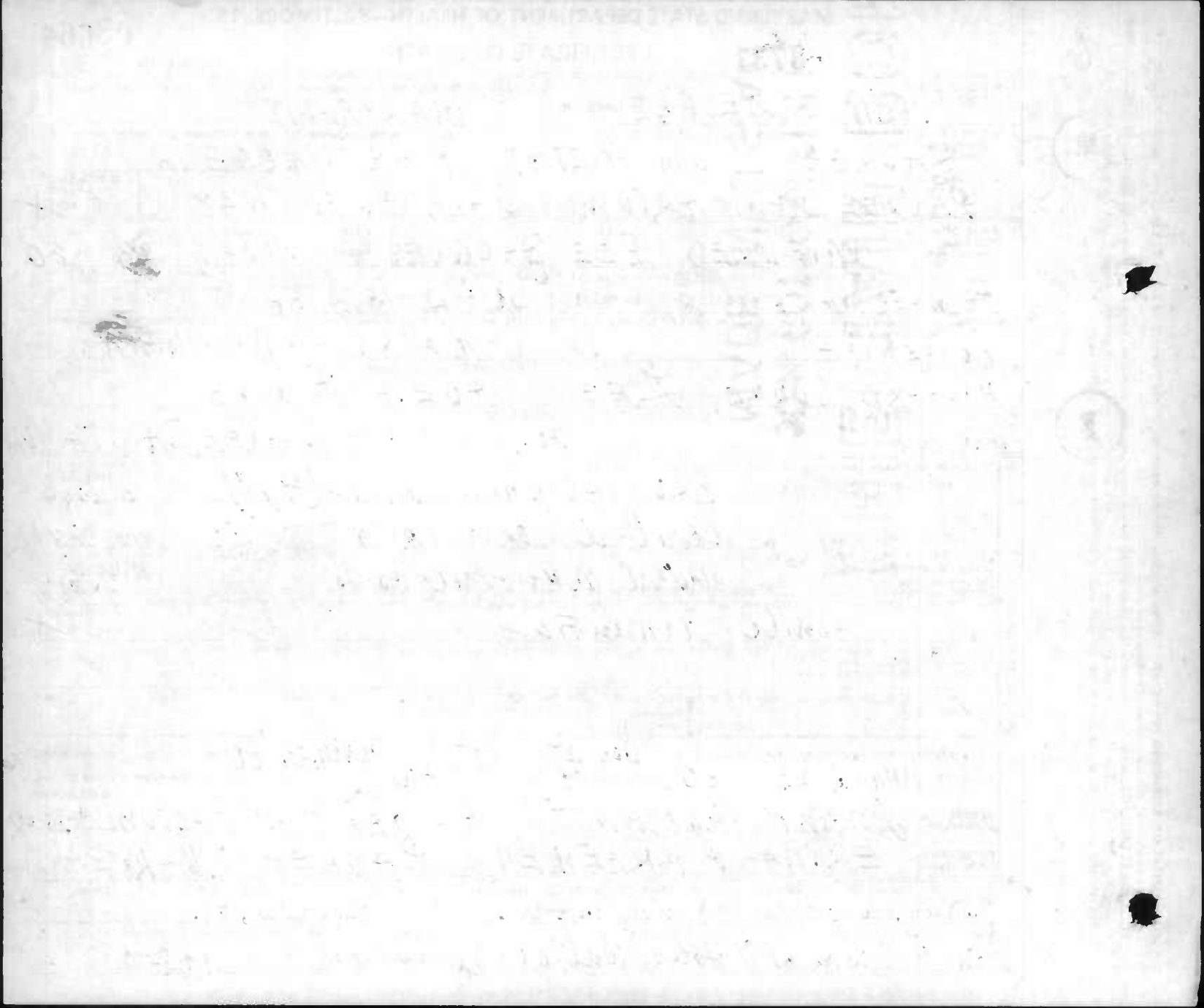
03664

3731

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN 1b adm. Dec 27-57	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MILDRED LEE JACQUES		4. DATE OF DEATH March 23 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 12-1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
13. FATHER'S NAME RICHARD CURREY LEE		14. MOTHER'S MAIDEN NAME ADEA LAWS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. Informant	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO pneumonia (491) 332X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) cerebral thrombosis (c) cardiac arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 6 days one week several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senile dementia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 27 , 19 57 , to March 23 19 60 that I last saw the deceased alive on March 23 , 19 60 , and that death occurred at 7:24 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Erika P. Kraemer M.D.		DATE SIGNED March 23-60	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL SANITARIUM	
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		22b. DATE THEREOF 3/26/60	
22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		22d. LOCATION (City, town, or county) (State) Pikesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Sons - Balt 17		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
		24b. REGISTRAR'S SIGNATURE William L. Thomas	



CERTIFICATE OF DEATH

03665

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chapel Oaks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Chapel Oaks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1429-58" Ave.</i>		d. STREET ADDRESS <i>1429-58" Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Olden</i> Middle <i>Johnson</i> Last		4. DATE OF DEATH Month <i>March</i> Day <i>14</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 15, 1893</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>11</i> Days <i>29</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Under Master</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	
11. BIRTHPLACE (State or foreign country) <i>Richmond Co. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>578-03-7107</i>	
17. INFORMANT <i>Mr. Edith Smith</i>		Address <i>1429-58" Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Heart Attack</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Heart Disease</i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. 16 min.</i> <i>2 yrs -</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Natural Conditions of age</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <i>11</i> p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1948</i> , 19 <i>3-14</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>3-14-1960</i> , and that death occurred at <i>5:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Robinson</i> M.D.		ADDRESS (Street, city or town, state) <i>1001 Eastern Ave. NE.</i> DATE SIGNED <i>3/14/60</i>	
PHYSICIAN'S NAME (Type) <i>John W. Robinson, M.D.</i>		<i>Washington 27, D.C.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Mar-18-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Rhines & Co.</i>		ADDRESS <i>3015 12th St., N. E.</i>	
24a. REC'D BY REGISTRAR <i>MAR 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hays</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3766

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>PRINCE GEORGE MARYLAND</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MARYLAND</i> b. COUNTY <i>PR. GEO.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BRADBURY Hgts</i>				c. LENGTH OF STAY IN 1b <i>25 BRADBURY Hgts.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>5219-V-ST. SE.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>VALENTINE M.</i> Middle <i>JOSLIN</i> Last <i>JOSLIN</i>				4. DATE OF DEATH Month <i>MAR.</i> Day <i>4</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>APR. 4 - 1895</i>	
9. AGE (In years lost birthday) yrs. <i>64</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Horsewife</i>		11. BIRTHPLACE (State or foreign country) <i>LOUISIANA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Ernest Guilbeau</i>				14. MOTHER'S MAIDEN NAME <i>Guilbeau</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>		INFORMANT Address <i>Wilbur Joslin - 5219-V-ST. SE.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senescent Carcinomatosis</i> <i>153.8</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of Colon.</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb.</i> , 1958, to <i>Mar. 4</i> , 1960, that I last saw the deceased alive on <i>Mar. 3</i> , 1960, and that death occurred at <i>9:35 AM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. H. Thibadeau</i>				ADDRESS (Street, city or town, state) <i>3112-Ald. Ave S.E., Wash 20, D.C.</i>			
PHYSICIAN'S NAME (Type) <i>J. H. Thibadeau</i>				DATE SIGNED <i>Mar 4, 1960</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-8-60</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Natl.</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington 2A.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Summers Bros.</i>				ADDRESS <i>1661-Good Hope Rd SE Wash 20 SE</i>		24a. REC'D BY REGISTRAR <i>MAR 7 '60</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

STATE OF NEW YORK

3766

OFFICE OF THE ATTORNEY GENERAL

NEW YORK

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03667

3767 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hill Crest Heights				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION at home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS 2308 Kirby Dr.	
3. NAME OF DECEASED (Type or print) First Middle Last John W. King.				4. DATE OF DEATH Month Day Year March 8th 1960 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-8-1872	
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self employed				10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Westmoreland Co. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Waller King				14. MOTHER'S MAIDEN NAME Emma Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Franklin Bilas 2308 Kirby Dr. Hill Crest Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uremia - Pyelonephritis</u> INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Silver Hill, Md.				20g. (County) Prince George		20h. (State) Maryland	
21. I certify that I attended the deceased from January 1959, to Present, that I last saw the deceased alive on March 5, 1960, and that death occurred at 3:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John P. D'Agelo M.D.</u> M.D. 4223 Silver Hill Rd				PHYSICIAN'S NAME (Type) <u>John P. D'Agelo M.D.</u> Silver Hill, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-11-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Co., Alexandria Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Demaine & Son.</u>				ADDRESS Alexandria Va.		24a. REC'D BY REGISTRAR DATE MAR 14 '60	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

CERTIFICATE OF DEATH

Reg. No.

<p>NAME OF DECEASED John V. Rice</p>		<p>DATE OF BIRTH []</p>	<p>PLACE OF BIRTH []</p>
<p>DATE OF DEATH []</p>		<p>PLACE OF DEATH []</p>	
<p>CAUSE OF DEATH []</p>		<p>DATE OF DEATH []</p>	

<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>
<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>
<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>

<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>
<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>
<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>

<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>
<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>
<p>DATE OF DEATH []</p>	<p>PLACE OF DEATH []</p>	<p>CAUSE OF DEATH []</p>	<p>DATE OF DEATH []</p>

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3690

CERTIFICATE OF DEATH

Reg. Dist. No.

03668

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pr. George Gen. Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PETER Middle L. Last KING				4. DATE OF DEATH Month Mar. 16th Day 19 Year 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5th 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Truck Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. King				14. MOTHER'S MAIDEN NAME Susana Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT George E. King		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 12, 19. 60 to Mar. 16, 19. 60 that I last saw the deceased alive on Mar. 16, 19. 60, and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6311 Baltimore Ave. Riverdale Md 3-17-60 ACTUAL SIGNATURE David S. Clayman M.D. PHYSICIAN'S NAME (Type) Dr. David S. Clayman 6311--Baltimore Ave, Riverdale, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 18-1960		22c. NAME OF CEMETERY OR CREMATORY St. Barnbas Cemetery		22d. LOCATION (City, town, or county) (State) Oxon Hill, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 1661--Good Hope Road SE Washington, D.C.				24a. REC'D BY REGISTRAR DATE MAR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

CENTRAL BUREAU OF HEALTH

3680

1. Name of patient: [illegible]
2. Age: [illegible]
3. Sex: [illegible]
4. Date of birth: [illegible]
5. Date of admission: [illegible]
6. Date of discharge: [illegible]
7. Name of attending physician: [illegible]
8. Name of hospital: [illegible]
9. Name of city: [illegible]
10. Name of state: [illegible]
11. Name of country: [illegible]
12. Name of street: [illegible]
13. Name of house: [illegible]
14. Name of room: [illegible]
15. Name of ward: [illegible]
16. Name of bed: [illegible]
17. Name of nurse: [illegible]
18. Name of doctor: [illegible]
19. Name of pharmacist: [illegible]
20. Name of dietitian: [illegible]
21. Name of janitor: [illegible]
22. Name of porter: [illegible]
23. Name of attendant: [illegible]
24. Name of visitor: [illegible]
25. Name of relative: [illegible]
26. Name of friend: [illegible]
27. Name of neighbor: [illegible]
28. Name of acquaintance: [illegible]
29. Name of stranger: [illegible]
30. Name of unknown: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG258 3-7-60 et

3768

CERTIFICATE OF DEATH

13669

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxon Hill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OXON RUN HILLS</u> 18	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		d. STREET ADDRESS <u>5057 DUNLAP ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>WALDO</u> Middle <u>D.</u> Last <u>KING</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>1</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 1. 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAINTENANCE</u>	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-054589</u>	
17. INFORMANT <u>MAY. V. BARRITT</u>		Address <u>5057 DUNLAP ST. S.E.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Cancer of Rectum</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1-1959</u> to <u>3-1-1960</u> , that I lost saw the deceased alive on <u>2/29</u> , 19 <u>60</u> , and that death occurred at <u>5:45</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis Parker</u>		ADDRESS (Street, city or town, state) <u>5241 St. Barnabas Rd</u>	
PHYSICIAN'S NAME (Type) <u>Lewis Parker MD</u>		DATE SIGNED <u>3/1/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>		22b. DATE THEREOF <u>3/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Wm. Lees Sons Co.</u>		ADDRESS <u>300-4th St. N.E.</u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 3 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

3729

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREENBELT</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X GREENBELT</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 H. RIDGE RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE MAE KNEECE</u>				4. DATE OF DEATH Month Day Year <u>MARCH 21, 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 9, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>AUGUSTA, GEORGIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>247-10-3790</u>		17. INFORMANT <u>Ray F. Kneece</u> Address <u>25 H Ridge Rd Greenbelt Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> <u>cerebrovascular accident</u> DUE TO <u>cerebral artery occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) <u>hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic cerebrovascular disease; hemiplegia</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8:20</u> , 19 <u>60</u> , to <u>7:21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3-20</u> , 19 <u>60</u> , and that death occurred at <u>8:00</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4314 Gallatin St. Hyattsville, Md.</u> DATE SIGNED <u>Y. H. Bergeman</u> ACTUAL SIGNATURE <u>Y. H. Bergeman</u> M.D. <u>4314 Gallatin St. Hyattsville, Md.</u> PHYSICIAN'S NAME (Type) <u>Till Bergeman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Graniteville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Graniteville, S. Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co., Riverdale, Md.</u> ADDRESS <u>Riverdale, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneese</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3691

CERTIFICATE OF DEATH

Reg. Dist. No.

03671

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 11 Hr 50 Min	
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Baby Girl		4. DATE OF DEATH Mar. 14 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 14 1960
9. AGE (In years last birthday) yrs. 11		IF UNDER 1 YEAR 11 Months 50 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alvin Friend		14. MOTHER'S MAIDEN NAME Grace Sarah Knox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) atelectasis 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prematurity DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Mongolism INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Mar 14 , 19 60 , to Mar 14 , 19 60 , that I last saw the deceased alive on March 14 , 19 60 , and that death occurred at 2:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE John W. Perkins		ADDRESS (Street, city or town, state) 5301 Hamilton St., Hyattsville, Md. DATE SIGNED 3/14/60	
PHYSICIAN'S NAME (Type) Dr. John Perkins, M.D.		5301 Hamilton St. Hyattsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/15/60	
22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) _____ (State) _____	
23. MEDICAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.		24a. REC'D BY REGISTRAR DATE MAR 18 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3692 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03672

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2/ Forestville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital				d. STREET ADDRESS 5478 Spring Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Frank Krause				4. DATE OF DEATH Month Day Year March 9 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 1, 1905		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Meat		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Luther Krause				14. MOTHER'S MAIDEN NAME Bertha Sauma			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579-12-1959		17. INFORMANT Address Mrs. Anna Pischke, same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart Failure, Cerebral edema</u> 322.2 DUE TO <u>Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James I. Boyd</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED March 10, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-1960		22c. NAME OF CEMETERY OR CREMATORY Washington Nat'l		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Mattingly Wash DC				24a. REC'D BY REGISTRAR DATE MAR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

MEDICAL CERTIFICATION

2

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G259 3-30-60 et

03673

CERTIFICATE OF DEATH

Reg. Dist. No.

3662

1. PLACE OF DEATH COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN lb 8 Mos. 1 Day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. S. Bell's Nursing Home for Children		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sandra Lynn Lippincott		4. DATE OF DEATH March 22 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/59
9. AGE (In years last birthday) 1		10. IF UNDER 1 YEAR Months 2 Days 7 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) San Diego, Calif.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Patricia Lippincott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nursing Home Records		6403 Ager Road Hyattsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 351X cerebral palsy with general spasticity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral agensis DUE TO (c) Terminal respiratory paralysis		INTERVAL BETWEEN ONSET AND DEATH Birth on Birth on	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 July 1959, to 3/22 1960, that I last saw the deceased alive on 3/22 1960, and that death occurred at 7 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas A. Christensen M.D.		ADDRESS (Street, city or town, state) College Park, Maryland	
PHYSICIAN'S NAME (Type) Thomas A. Christensen		DATE SIGNED 3/24/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) 3.22.60		22b. NAME OF CEMETERY OR CREMATORY U of Md. Med. School	
22c. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Francis gasch's Sons		24a. REC'D BY REGISTRAR Hyattsville, Md.	
24b. REGISTRAR'S SIGNATURE		DATE MAR 24 '60	

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800-202-2150

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3739

CERTIFICATE OF DEATH

Reg. Dist. No.

03674

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. LENGTH OF STAY IN 1b 5 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4609 Riverdale Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ernest Eastman Lovejoy				4. DATE OF DEATH Month March Day 21 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1871		9. AGE (In years and birthday) 88 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Illinois	
12. CITIZEN OF WHAT COUNTRY? U, S. A.				13. FATHER'S NAME Abion Lovejoy			
14. MOTHER'S MAIDEN NAME Margaret Eastman				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Mabelle L. Munch Address Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 9-12 , 19 58 , to 3-8 , 19 60 , that I last saw the deceased alive on 3-8 , 19 60 , and that death occurred at 12:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE D R Purdie				ADDRESS (Street, city or town, state) 4404 Leesburg Rd. Riverdale, Md. DATE SIGNED 3-21-60			
PHYSICIAN'S NAME (Type) D R Purdie				22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 3/22/60			
22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY Rantoul, Illinois			
22d. LOCATION (City, town, or county) (State) Illinois				24a. REC'D BY REGISTRAR MAR 24 '60			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.				24b. REGISTRAR'S SIGNATURE Anthony B. Kung			

3745

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Pr Geos Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seat Pleasant</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 Seat Pleasant</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6706 F St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Milton Mace</u>		4. DATE OF DEATH Month Day Year <u>March 8 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24 1888</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inquiry Section</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Post Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Mace</u>		14. MOTHER'S MAIDEN NAME <u>unk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-52-9122</u>	
17. INFORMANT <u>Mrs. Elizabeth Mace</u>		Address <u>6706 F St Seat Pleasant Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of Aortic Aneurysm</u> 451X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> (b) <u>Viral Bronchitis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 17 1958</u> to <u>March 8 1960</u> , that I last saw the deceased alive on <u>March 7 1960</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Sait Ritchie</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7005 Ritchie Rd S.E. Wash 27 D.C.</u> <u>3/8/60</u>	
PHYSICIAN'S NAME (Type) <u>W. Sait Ritchie M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Smithland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>See Funeral Home Wash D.C.</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased John Doe</p>		<p>2. Sex Male</p>		<p>3. Age 45</p>	
<p>4. Date of death 1945</p>		<p>5. Time of death 10:00 AM</p>		<p>6. Place of death Home</p>	
<p>7. Cause of death Heart Disease</p>		<p>8. Manner of death Natural</p>		<p>9. Signature of physician Dr. J. Smith</p>	
<p>10. Signature of registrar J. Doe</p>		<p>11. Signature of informant J. Doe</p>		<p>12. Signature of witness J. Doe</p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

03676

3693

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MARYLAND Prince Georges				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 1 da.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ulysses Middle Mackall Last Mackall				4. DATE OF DEATH Month March Day 27 Year 1960			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH I-15-79	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government				10b. KIND OF BUSINESS OR INDUSTRY Maryland			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME James Mackall				14. MOTHER'S MAIDEN NAME Martha Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Susie Mackall 705. Addison Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 27, 1960 to March 27, 1960 , that I last saw the deceased alive on March 27, 1960 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6311 Baltimore Road, Md. DATE SIGNED 3/27/60 ACTUAL SIGNATURE David S. Clayman PHYSICIAN'S NAME (Type) David S. Clayman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 4-1-60				22b. DATE THEREOF 4-1-60			
22c. NAME OF CEMETERY OR CREMATORY National Harmony Md.				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE John F. Stewart				24. REC'D BY REGISTRAR DATE APR 1 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Evans							

10

3023

STATE OF TEXAS

County of _____

Shirley _____

Shirley _____

Shirley _____

Shirley _____

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3694 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month March Day 19 Year 1960		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 25 Dec. 1889		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Government Clerk	
11. BIRTHPLACE (State or foreign country) Montana		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Mail		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Winona M Hutchson		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive pul. embolus 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sarcom at os DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 12 1960 , to MARCH 19 1960 that I last saw the deceased alive on MARCH 19 1960 , and that death occurred at 11:35 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Bernard Peacock M.D.		DATE SIGNED 5/23/60	
PHYSICIAN'S NAME (Type) BERNARD PEACOCK		WASHINGTON D. C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/60	
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR MAR 24 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3695

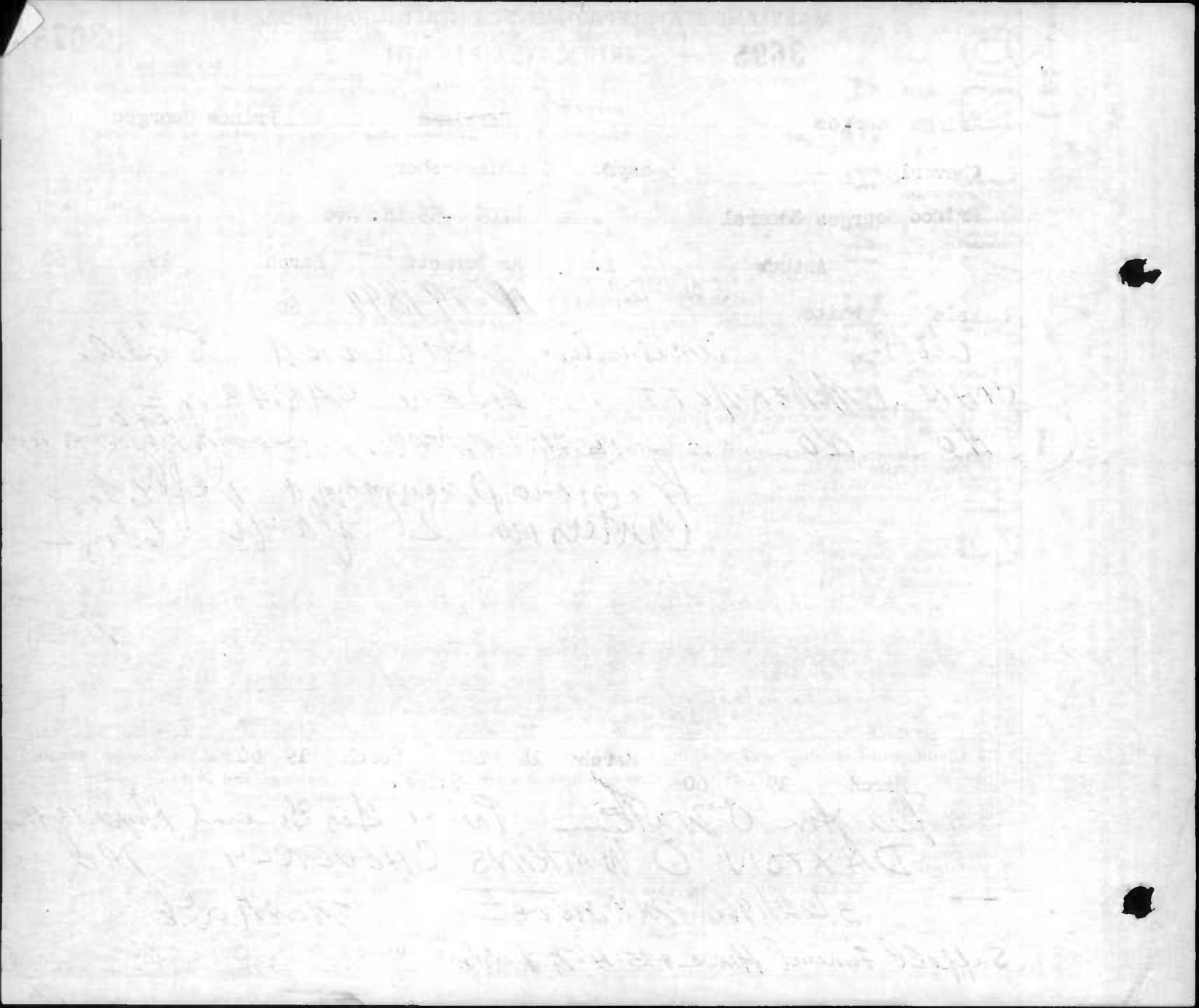
CERTIFICATE OF DEATH

Reg. Dist. No.

03678

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Georges				c. LENGTH OF STAY IN 1b 5 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle A. Last Mc Dermott				4. DATE OF DEATH Month March Day 19 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-79-1899	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN J. McDERMOTT		14. MOTHER'S MAIDEN NAME ELLEN CARABINE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. 574-03-8472		17. INFORMANT MARY McDERMOTT		Address 1843 MATHWOOD PLANE		INTERVAL BETWEEN ONSET AND DEATH 6 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.0 DUE TO broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intentional self-harm DUE TO 6 days (c) Fall							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall -- Fell at home and injured hip			
20c. TIME OF INJURY Month, Day, Year Hour a. m. Unk. p. m. Unk. 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- Home		20f. (City or town) (County) (State) Bladensburg Pr. Geo Md.	
21. I certify that I attended the deceased from March 14, 1960 , to March 19, 1960 , that I last saw the deceased alive on March 19, 1960 , and that death occurred at 9:55 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dayton O Watkins M.D.				ADDRESS (Street, city or town, state) Prince Georges General Hospital DATE SIGNED April 13 1960			
PHYSICIAN'S NAME (Type) DAYTON O WATKINS				CHEVERLY Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3/22/1960		22b. DATE THEREOF 3/22/1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Wash DC	
23. FUNERAL DIRECTOR'S SIGNATURE Saffell Funeral Home ADDRESS 475-H-7th St				24a. REC'D BY REGISTRAR DATE MAR 22 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03679

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> (COUNTY) <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rosaryville</u>			
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>FRANK</u>		First Middle Last <u>McGuillivray</u>		4. DATE OF DEATH <u>3</u> <u>8</u> <u>1960</u>		Month Day Year	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Real construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Mr. Berry Woods</u> Address <u>Rosaryville, Md.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>932.0</u> DUE TO <u>Exposure to Cold</u>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found on floor of home dead speed</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>				20f. (City or town) (County) (State) <u>P.G.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
Address (Street, city, town, or county) <u>3-9-60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-15-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>MAR 17 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

10038

MASSACHUSETTS DEPARTMENT OF HEALTH
BUREAU OF STATISTICAL RESEARCH AND RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3036

THE STATE
OF MASSACHUSETTS

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, cause of death, and signature of medical examiner. The form is mostly blank with some faint markings.



MAILED 1-1-60

3697

CERTIFICATE OF DEATH

Reg. Dist. No.

03680

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevely				c. LENGTH OF STAY IN 1b 31 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Melissa J. Moore				4. DATE OF DEATH Month Day Year March 10 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-18 -96	
9. AGE (In years lost birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME William C Kroh				14. MOTHER'S MAIDEN NAME Annie Grubb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no			
17. INFORMANT Address Viola R Grubb 420 N 2nd St Wormleysburg Pa.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Shock 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spontaneous Rupture of Esophagus DUE TO (c) 1 week							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gangrene of Terminal Ileum							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/9/60 , 19 60 , to 3/10 , 19 60 , that I last saw the deceased alive on 3/10 , 19 60 , and that death occurred at 1:45 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3408 Rhode Island Ave Mt. Rainier, Md. DATE SIGNED 3/10/60							
ACTUAL SIGNATURE Leon R. Levitsky M.D.							
PHYSICIAN'S NAME (Type) Leon R. Levitsky							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 14, 1960		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons ADDRESS Hyattsville, Maryland.				24a. REC'D BY REGISTRAR MAR 15 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3769

CERTIFICATE OF DEATH

Reg. Dist. No. 03681

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Piscatway</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Piscatway</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rt. 2 Box 196 Floral Pk. Rd.</u>				d. STREET ADDRESS <u>Rt. 2 Box 196 Floral Pk. Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PALMER</u> Middle <u>J.</u> Last <u>MULLINS</u>				4. DATE OF DEATH Month <u>Mar.</u> Day <u>8</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 June 1911</u>		9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mullins</u>				14. MOTHER'S MAIDEN NAME <u>Della Borgan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1941-1946</u>		17. INFORMANT <u>Myrtle C Mullins-Same#2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>180X Dementia coronaria</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 53</u> , 19 <u>52</u> , to <u>March 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 8</u> , 19 <u>60</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bundick, Md.</u> DATE SIGNED <u>Bundick, Md.</u>							
ACTUAL SIGNATURE <u>Robert D. Doherty</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robert D. Doherty</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arl Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funera 1</u> ADDRESS <u>Home 300-4th St. N. E. DC</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Caroline S. Frank</u>	

CERTIFICATE OF DEATH

1158

PLACE OF DEATH		MARRIAGE	
COUNTY		MARRIAGE	
CITY OR TOWN		CITY OR TOWN	
STREET		STREET	
DATE OF DEATH		DATE OF DEATH	
HOUR		HOUR	
MINUTE		MINUTE	
SECOND		SECOND	
AGE		AGE	
SEX		SEX	
RACE		RACE	
RELIGION		RELIGION	
EDUCATION		EDUCATION	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
PLACE OF BURIAL		PLACE OF BURIAL	
DATE OF BURIAL		DATE OF BURIAL	
HOUR OF BURIAL		HOUR OF BURIAL	
MINUTE OF BURIAL		MINUTE OF BURIAL	
SECOND OF BURIAL		SECOND OF BURIAL	
AGE AT BURIAL		AGE AT BURIAL	
SEX AT BURIAL		SEX AT BURIAL	
RACE AT BURIAL		RACE AT BURIAL	
RELIGION AT BURIAL		RELIGION AT BURIAL	
EDUCATION AT BURIAL		EDUCATION AT BURIAL	
OCCUPATION AT BURIAL		OCCUPATION AT BURIAL	
CAUSE OF BURIAL		CAUSE OF BURIAL	
MANNER OF BURIAL		MANNER OF BURIAL	
PLACE OF INTERMENT		PLACE OF INTERMENT	
DATE OF INTERMENT		DATE OF INTERMENT	
HOUR OF INTERMENT		HOUR OF INTERMENT	
MINUTE OF INTERMENT		MINUTE OF INTERMENT	
SECOND OF INTERMENT		SECOND OF INTERMENT	
AGE AT INTERMENT		AGE AT INTERMENT	
SEX AT INTERMENT		SEX AT INTERMENT	
RACE AT INTERMENT		RACE AT INTERMENT	
RELIGION AT INTERMENT		RELIGION AT INTERMENT	
EDUCATION AT INTERMENT		EDUCATION AT INTERMENT	
OCCUPATION AT INTERMENT		OCCUPATION AT INTERMENT	
CAUSE OF INTERMENT		CAUSE OF INTERMENT	
MANNER OF INTERMENT		MANNER OF INTERMENT	
PLACE OF CREMATION		PLACE OF CREMATION	
DATE OF CREMATION		DATE OF CREMATION	
HOUR OF CREMATION		HOUR OF CREMATION	
MINUTE OF CREMATION		MINUTE OF CREMATION	
SECOND OF CREMATION		SECOND OF CREMATION	
AGE AT CREMATION		AGE AT CREMATION	
SEX AT CREMATION		SEX AT CREMATION	
RACE AT CREMATION		RACE AT CREMATION	
RELIGION AT CREMATION		RELIGION AT CREMATION	
EDUCATION AT CREMATION		EDUCATION AT CREMATION	
OCCUPATION AT CREMATION		OCCUPATION AT CREMATION	
CAUSE OF CREMATION		CAUSE OF CREMATION	
MANNER OF CREMATION		MANNER OF CREMATION	
PLACE OF REINTERMENT		PLACE OF REINTERMENT	
DATE OF REINTERMENT		DATE OF REINTERMENT	
HOUR OF REINTERMENT		HOUR OF REINTERMENT	
MINUTE OF REINTERMENT		MINUTE OF REINTERMENT	
SECOND OF REINTERMENT		SECOND OF REINTERMENT	
AGE AT REINTERMENT		AGE AT REINTERMENT	
SEX AT REINTERMENT		SEX AT REINTERMENT	
RACE AT REINTERMENT		RACE AT REINTERMENT	
RELIGION AT REINTERMENT		RELIGION AT REINTERMENT	
EDUCATION AT REINTERMENT		EDUCATION AT REINTERMENT	
OCCUPATION AT REINTERMENT		OCCUPATION AT REINTERMENT	
CAUSE OF REINTERMENT		CAUSE OF REINTERMENT	
MANNER OF REINTERMENT		MANNER OF REINTERMENT	

RECEIVED
BIRTH-DEATH-18

1158

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03682

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) o. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		83x3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>				d. STREET ADDRESS <u>911- N. Wayne Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Wesley</u> Last <u>Mutchler</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chemical</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Marshall Mutchler</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Ann Tucker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>225-05-2830</u>		17. INFORMANT <u>Margaret Mutchler; same address as # 2.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardiovascular disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause lost. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>March 24, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 28, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home - Washington, D.C.</u>				ADDRESS <u>Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 28 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

STATE OF TEXAS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of medical examiner	
9. Signature of physician		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of registrar	
17. Signature of health officer		18. Signature of medical examiner		19. Signature of coroner		20. Signature of jury	
21. Signature of witnesses		22. Signature of funeral director		23. Signature of undertaker		24. Signature of cemetery	
25. Signature of registrar		26. Signature of health officer		27. Signature of medical examiner		28. Signature of coroner	
29. Signature of jury		30. Signature of witnesses		31. Signature of funeral director		32. Signature of undertaker	
33. Signature of cemetery		34. Signature of registrar		35. Signature of health officer		36. Signature of medical examiner	
37. Signature of coroner		38. Signature of jury		39. Signature of witnesses		40. Signature of funeral director	
41. Signature of undertaker		42. Signature of cemetery		43. Signature of registrar		44. Signature of health officer	
45. Signature of medical examiner		46. Signature of coroner		47. Signature of jury		48. Signature of witnesses	
49. Signature of funeral director		50. Signature of undertaker		51. Signature of cemetery		52. Signature of registrar	
53. Signature of health officer		54. Signature of medical examiner		55. Signature of coroner		56. Signature of jury	
57. Signature of witnesses		58. Signature of funeral director		59. Signature of undertaker		60. Signature of cemetery	
61. Signature of registrar		62. Signature of health officer		63. Signature of medical examiner		64. Signature of coroner	
65. Signature of jury		66. Signature of witnesses		67. Signature of funeral director		68. Signature of undertaker	
69. Signature of cemetery		70. Signature of registrar		71. Signature of health officer		72. Signature of medical examiner	
73. Signature of coroner		74. Signature of jury		75. Signature of witnesses		76. Signature of funeral director	
77. Signature of undertaker		78. Signature of cemetery		79. Signature of registrar		80. Signature of health officer	
81. Signature of medical examiner		82. Signature of coroner		83. Signature of jury		84. Signature of witnesses	
85. Signature of funeral director		86. Signature of undertaker		87. Signature of cemetery		88. Signature of registrar	
89. Signature of health officer		90. Signature of medical examiner		91. Signature of coroner		92. Signature of jury	
93. Signature of witnesses		94. Signature of funeral director		95. Signature of undertaker		96. Signature of cemetery	
97. Signature of registrar		98. Signature of health officer		99. Signature of medical examiner		100. Signature of coroner	

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (When deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Switland</u>		c. LENGTH OF STAY IN lb <u>24 Switland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4470 Oak Drive</u>		d. STREET ADDRESS <u>4470 Oak Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Maechen</u> Middle <u>Maechen</u> Last		4. DATE OF DEATH <u>March 13 - 1960</u> Month <u>March</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 9-1881</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>	
13. BIRTHPLACE (State or foreign country) <u>Wash D C</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. FATHER'S NAME <u>Ludwig Maechen</u>		16. MOTHER'S MAIDEN NAME <u>Sophie Seemann</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO.	
19. INFORMANT <u>Pauline Kehn</u> Address <u>Lamesa #2</u>			
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASH-D</u> (b) <u>Old CVA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Hour a.m. p.m. Month, Day, Year <u>1960</u>		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I attended the deceased from <u>2/16</u> 19 <u>60</u> to <u>3-13</u> 19 <u>60</u> , that I last saw the deceased alive on <u>3/13/60</u> 19 <u>60</u> , and that death occurred at <u>7:15 P.</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Timothy F. O'Donovan</u> M.D. <u>2811 Pa Ave S.E. Wash, D.C.</u>		<u>3-13-60</u>	
PHYSICIAN'S NAME (Type) <u>Timothy F. O'Donovan</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE THEREOF	
<u>Burial</u>		<u>3-17-1960</u>	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
<u>Congressional</u>		<u>Wash D C</u>	
25. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
<u>Robert A. Mattingly</u>		<u>Wash, D.C.</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>MAR 16 '60</u>	
<u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

3770

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

FILE NO.

DATE OF DEATH

DEATH PLACE

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

3699

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 Oxen Hill			
				d. STREET ADDRESS 6041 St. Barnibus Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ronnie- Baby Boy				4. DATE OF DEATH Month March Day 15 Year 1960			
5. SEX Male		6. COLOR OR RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 Feb 1960	
9. AGE (In years last birthday) 17		10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME James R. Newman				14. MOTHER'S MAIDEN NAME Dorothy M Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Mother Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prematurity & Immaturity DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb. 27 , 19 60 , to Mar. 15 , 19 60 that I last saw the deceased alive on Mar. 15 , 19 60 , and that death occurred at 3:55A M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lewis Parker				ADDRESS (Street, city or town, state) 5241 St. Barnabas Road Temple Hills, Md.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) Dr. Lewis Parker., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation				22b. DATE THEREOF 3/29/60		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr.				ADDRESS Administrator		24a. REC'D BY REGISTRAR DATE APR 5 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knead			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9-58

TO POWERED DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1 b & d, Film G258 3/11/60 iwk

3771

CERTIFICATE OF DEATH

03685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale, W. Hyattsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2227 Beechwood Rd.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale, Hyattsville 58</u> d. STREET ADDRESS <u>2227 Beechwood Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>PAULINO</u> Last <u>PHILIP</u> 4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1960</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov 14, 1891</u> 9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months <u>6</u> Days <u>11</u> Hours <u>11</u> Min. IF UNDER 24 HRS. Months <u>6</u> Days <u>11</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurateur</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (State or foreign country) <u>Italy</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Angelo Palumbo</u> 14. MOTHER'S MAIDEN NAME <u>Josephine Salerno</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WAR I</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Mrs Josephine Hannon</u> Address <u>2227 Beechwood Rd Hyattsville Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiac/vascular</u> <u>442X</u> DUE TO <u>hepatic sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>April</u> Day <u>23</u> Year <u>1956</u> Hour <u>19</u> a. m. <u>56</u> p. m. 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>35 N Y Ave NW Wash DC</u> 20f. (City or town) <u>Washington</u> (County) <u>D.C.</u> (State) <u>D.C.</u>		21. I certify that I attended the deceased from <u>April 23, 1956</u> to <u>Feb 29, 1960</u> that I last saw the deceased alive on <u>29 Feb</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Robert C. Haile</u> M.D. PHYSICIAN'S NAME (Type) <u>Robert C. Haile</u>		DATE SIGNED <u>3 Mar 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u> 22b. DATE THEREOF <u>3-7-1960</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincolns Mausoleum</u> 22d. LOCATION (City, town, or county) <u>Bladensburg Md.</u> (State) <u>Md.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Knaus</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u> ADDRESS <u>Riversdale, Md.</u> DATE <u>MAR 7 '60</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3700

CERTIFICATE OF DEATH

Reg. Dist. No.

03686

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 18 hr. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Booker W. Parker				4. DATE OF DEATH Month Day Year March 11 1960			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-22-99	
9. AGE (In years lost birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Parker				14. MOTHER'S MAIDEN NAME Susan Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Elizabeth M. Parker Bowie Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac failure DUE TO (c) Arteriosclerotic and hypertensive heart disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Constrictive pericarditis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore				20g. (County) Baltimore		20h. (State) Md	
21. I certify that I attended the deceased from March 13 1960 , to March 14 1960 , that I last saw the deceased alive on March 11 1960 , and that death occurred at 5:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE David S. Clayman				ADDRESS (Street, city or town, state) 6311 Baltimore Ave. Riverdale Md			
DATE SIGNED 3/11/60							
PHYSICIAN'S NAME (Type) Dr. David S. Clayman, M.D.				6311 Baltimore Ave. Riverdale Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-17-1960		22c. NAME OF CEMETERY OR CREMATORY Faulks		22d. LOCATION (City, town, or county) (State) Wilsonson Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese # Anna Md				ADDRESS 6311 Baltimore Ave. Riverdale Md		24a. REC'D BY REGISTRAR DATE MAR 16 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3700

1910

[Faint, illegible text, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3732

CERTIFICATE OF DEATH

Reg. Dist. No.

103687

1. PLACE OF DEATH o. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>320 Washington Blvd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>L.</u> Last <u>Pentz</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24 1871</u>	
9. AGE (In years last birthday) <u>88 yrs.</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>		IF UNDER 24 HRS. Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min. <u>8</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Manchester New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Q Adams</u>				14. MOTHER'S MAIDEN NAME <u>Ella L. Lawrence</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or (unknown)) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>MISS ALICE HAWARD LAUREL MD</u>			
17. INFORMANT Address <u>320 Wash Blvd</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure 1 day</u> <u>422, 1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C.V. Dis 5 yrs</u> DUE TO (c) <u>Hypertension 20 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 1</u> , 19 <u>46</u> , to <u>3/20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/19</u> , 19 <u>60</u> , and that death occurred at <u>4 p.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Laurel</u> DATE SIGNED <u>3/20/60</u> ACTUAL SIGNATURE <u>J M Warren</u> M.D. PHYSICIAN'S NAME (Type) <u>JOHN M. WARREN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/22/60</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>De Bais Pennsylvania</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>De Witt Donaldson, Laurel, Md</u>				24a. REGISTRY BY REGISTRAR DATE <u>Mar 28 60</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

CERTIFICATE OF DEATH

373

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
JAMES EARL RAY		Male		35		April 14, 1928		Memphis, Tennessee		None		Single		White	
9. CAUSE OF DEATH		10. MANNER OF DEATH		11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESS	
FIRE		Accident		Home		April 4, 1968		10:15 PM		[Signature]		[Signature]		[Signature]	
17. HISTORY OF ILLNESS		18. PRESENT ILLNESS		19. TREATMENT		20. POSTMORTEM EXAMINATION		21. OTHER INFORMATION		22. SIGNATURE OF PHYSICIAN		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF WITNESS	
None		None		None		None		None		None		None		None	

RECEIVED
MAY 10 1968
BALTIMORE, MARYLAND

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND STATISTICS ACT, CHAPTER 43, SECTION 1-101, MARYLAND CODE, 1959, AS AMENDED.

3772

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East River</u>		c. LENGTH OF STAY IN lb <u>20 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stoucken M.E. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ettie</u> First <u>Catherine</u> Middle <u>Platt</u> Last		4. DATE OF DEATH <u>3</u> Month <u>11</u> Day <u>1960</u> Year	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/5/83</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Leary Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Henkel</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT (Name) <u>Malcolm H. Platt</u> Address <u>1450 Monroe St</u>		18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.0</u> DUE TO <u>Arterio Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>59</u> , to <u>3/11</u> , 19 <u>60</u> , that I lost saw the deceased alive on <u>3/11</u> , 19 <u>60</u> , and that death occurred at <u>7:20</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis Parker</u>		ADDRESS (Street, city or town, state) <u>5241 SE. Oakbrook Rd. Wash D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Lewis Parker</u>		DATE SIGNED <u>3/11/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>13/1960 March</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Leakwill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Leary Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Dellinger & Son woodstock Va.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Clinton S. Thayer</u>			

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VS A1S (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2782

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3740

CERTIFICATE OF DEATH

Reg. Dist. No.

03689

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 Lanham			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial Hospital				d. STREET ADDRESS 1 Goodluck Rd. R # 1			
3. NAME OF DECEASED (Type or print) First IDA Middle T. Last PORT				4. DATE OF DEATH Month March Day 2 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-3-70	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Ret.				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Simon Speapher				14. MOTHER'S MAIDEN NAME Anna McGradeay			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Elmer I. Herr				Address Rt. #1, Box 388, Hospital Record Goodluck Rd. Lanham, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coroner's Heart Failure (c) Anteriorly located Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 6 weeks years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1-31, 1960, to 3-2, 1960, that I last saw the deceased alive on 3-2, 1960, and that death occurred at 10:00 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Roy B. Parsons Jr., M.D. PHYSICIAN'S NAME (Type) Roy B. Parsons Jr., M.D., 4404 Queensbury Rd., Riverdale, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 4, 1960		22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Cemetery Muirkirk		22d. LOCATION (City, town, or county) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md.				24a. REC'D BY REGISTRAR DATE MAR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES EARL RAY		M		35		12-1-28		MEMPHIS, TENN.	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR OF SKIN		9. HIGHEST SCHOOLING		10. RELIGION	
ATTORNEY		MARRIED		WHITE		HIGH SCHOOL		METHODIST	
11. DATE OF DEATH		12. TIME OF DEATH		13. PLACE OF DEATH		14. CAUSE OF DEATH		15. MANNER OF DEATH	
4-4-68		10:00 AM		HOME		HEART DISEASE		NATURAL	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESS		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CORONER		20. SIGNATURE OF REGISTRAR	
21. FULL NAME OF REGISTRAR		22. SIGNATURE OF REGISTRAR		23. FULL NAME OF PHYSICIAN		24. SIGNATURE OF PHYSICIAN		25. FULL NAME OF CORONER	
JAMES EARL RAY				JAMES EARL RAY				JAMES EARL RAY	
26. FULL NAME OF WITNESS		27. SIGNATURE OF WITNESS		28. FULL NAME OF PHYSICIAN		29. SIGNATURE OF PHYSICIAN		30. FULL NAME OF CORONER	
JAMES EARL RAY				JAMES EARL RAY				JAMES EARL RAY	

Reg. Dist. No.

VS A1S (4)
15M 9/5B

1. PLACE OF DEATH COUNTY Prince Geo. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE Maryland b. COUNTY Prince Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 33 Hyattsville (Cheverly)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7605 Kilmer St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Willard Albert Praytor		4. DATE OF DEATH Month Day Year March 17 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1909
9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Administrator		10b. KIND OF BUSINESS OR INDUSTRY Alabama	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Praytor		14. MOTHER'S MAIDEN NAME Nola Wallace	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War II		16. SOCIAL SECURITY NO. INFORMANT Mrs Ruth Praytor Address 7605 Kilmer St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Aortic Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C-V-D. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 4, 1960, to March 12, 1960, that I last saw the deceased alive on 12 March, 1960, and that death occurred at 9 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Thor M. Hutchins M.D. 4315 Landoner Rd PHYSICIAN'S NAME (Type) T.M. Hutchins Hyattsville, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/19/60	22c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery	22d. LOCATION (City, town, or county) (State) Alexandria Virginia
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.		24a. REC'D BY REGISTRAR DATE MAR 22 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



SECRET

CONFIDENTIAL

[Faint, mostly illegible handwritten text covering the majority of the page. Some words like "Dear", "I", "you", "very", "much", "love", "and", "affection" are faintly visible.]



Barclay 210000
S. S. Smith, 200000
H. S. Smith, 200000
H. S. Smith, 200000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND—BALTIMORE, 18
Item 1, Film G259, 3/18/60 1b
3666
CERTIFICATE OF DEATH

Reg. Dist. No.

03691

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 27 Capitol Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION AT HOME		d. STREET ADDRESS 16326 - 48th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Henry Middle Albert Last PRINCE, JR.		4. DATE OF DEATH Month March Day 13, Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-39
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Albert Prince, Sr.		14. MOTHER'S MAIDEN NAME Elizabeth Durham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES PT 9-7-57 to 3-6-58		16. SOCIAL SECURITY NO. 218-38-7138	
17. INFORMANT Joyce Prince - Wife 326 - 48th Avenue, Capitol Heights, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ewing's sarcoma with pulmonary metastases. 196.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Lobular pneumonia, massive, bilateral		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA Hosp Staff		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4-60, 19, to 3-13, 1960, that I last saw the deceased alive on 3-11, 1960, and that death occurred at 2:30 PM/3-13-60 from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 3-14-60	
ACTUAL SIGNATURE George A. Tralka M.D.			
PHYSICIAN'S NAME (Type) GEORGE A. TRALKA, M. D., VA Hospital, Washington, D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 16-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Summers Bros 1661-48th Ave NE Wash DC		24a. REC'D BY REGISTRAR DATE MAR 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3702 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03692

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>			c. LENGTH OF STAY IN 1b <u>D. O. A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oxoh Hill</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hosp</u>				d. STREET ADDRESS <u>7141 Livingston Road S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Alex</u> Last <u>Proctor</u>				4. DATE OF DEATH Month <u>March</u> , Day <u>9</u> , Year <u>19 60</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Color</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1886</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>John Francis Proctor</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Proctor</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Mary Irene Proctor, same as # 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) </div>							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. Month, Day, Year <u> 19 </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>James I. Boyd</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>March 9, 1960</u>		
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MARCH 12, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Oxoh Hill Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Rhines & Co.</u>				ADDRESS <u>3015-12th St. NE. D.C.</u>		24a. REC'D BY REGISTRAR <u>MAR 14 '60</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>								

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1905

NAME OF DECEASED SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION RESIDENCE DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF EXAMINER COUNTY OF STATE OF MASSACHUSETTS		NAME OF DECEASED SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION RESIDENCE DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF EXAMINER COUNTY OF STATE OF MASSACHUSETTS	
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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03693

3703

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALTON Middle R Last PYLES		4. DATE OF DEATH Month 3 Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 3 Days 5 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY C & P Tel. Co.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Pyles		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. #2 577-01-0460	
17. INFORMANT Anne Thelma Pyles		Address As Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH no 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 25 , 19 49 , to March 5 , 19 60 , that I last saw the deceased alive on Feb 19 , 19 60 , and that death occurred at 7 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE E. H. Mitchell M.D.			
PHYSICIAN'S NAME (Type) EARL H. MITCHELL, MD. 2029 - 9th St N.W. Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/9/60	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc Mt. Rainier, Md		24a. REC'D BY REGISTRAR DATE MAR 10 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Evans

CERTIFICATE OF DEATH

3703

Prince George

Prince George

Prince George

Age 45

B.O.B.

Occupation

0003 - 0011, 0012

Prince George Hospital

Physician

Sex

Attended

Dec. 8, 1905

White

U.S.A.

W. H. F. Co. Inc., Washington, D.C.

As Above

3703-01-0420 and other files

W. H. F. Co.

1905

and other files

1905

1905

1905

1905

1905

1905

1905

1905

1905

1905

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3741

CERTIFICATE OF DEATH

03694

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIVERDALE		c. LENGTH OF STAY IN 1b 21 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4908 TUCKERMAN ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PAUL Middle (PAVLO) Last QUATTRONE		4. DATE OF DEATH Month MARCH Day 22 Year 1960	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1 1891
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BRUNO QUATTRONE		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WAR I		16. SOCIAL SECURITY NO. 579-01-1771	
17. INFORMANT GRACE QUATTRONE		Address 4908 TUCKERMAN ST RIVERDALE, MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure 350x DUE TO Advanced Pulmonary Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 104 yrs. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-1 , 19 60 , to 3-22 , 19 60 , that I last saw the deceased alive on 3-22 , 19 60 , and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4314 Gallatin St. Hyattsville, Md. DATE SIGNED			
ACTUAL SIGNATURE A. Deitz		M.D. 4314 Gallatin St. Hyattsville, Md.	
PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT	22b. DATE THEREOF 3-26-60	22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN MAUSOLEUM	22d. LOCATION (City, town, or county) (State) BLADENSBURG MD
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co. Riverdale, Md		24a. REC'D BY REGISTRAR DATE MAR 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3733 CERTIFICATE OF DEATH

Reg. Dist. No.

03695

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b adm. Oct 30-57		1556.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LAUREL SANITARIUM		d. STREET ADDRESS 10 103 McKENNEY AVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ESTHER Middle G. Last REYNOLDS		4. DATE OF DEATH Month 3 Day 11 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept-5-1902
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MINNESOTA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LESLIE GADD		14. MOTHER'S MAIDEN NAME AMY L SWETT Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. INFORMANT Hosp. RECORDS LAUREL SANITARIUM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO CARDIAC FIBRILLATION (433.1) minutes Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) Myocardial Degeneration (c) (arteriosclerotic)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBRAL ATROPHY WITH MENTAL DETERIORATION		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 30 - , 19 57 , to 3-11- , 19 60 that I last saw the deceased alive on 3-11- , 19 60 , and that death occurred at 6:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Erika P. Kraemer M.D.		ADDRESS (Street, city or town, state) LAUREL SANITARIUM DATE SIGNED 3-11-60	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/14/60	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cem.		22d. LOCATION (City, town, or county) (State) Rising Sun, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Balt.		24a. REC'D BY REGISTRAR MAR 14 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

Reg. Dist. No.

03696

3704

1. PLACE OF DEATH a. COUNTY Prince George				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 Days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 70 College Park				d. STREET ADDRESS 5011 Fox St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) James				First R				Middle Riddle				Last Riddle				4. DATE OF DEATH Month Mar.				Day 12				Year 19 60											
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Feb. 28, 1887				9. AGE (In years lost birthday) 73 yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter								10b. KIND OF BUSINESS OR INDUSTRY Houses								11. BIRTHPLACE (State or foreign country) Maryland								12. CITIZEN OF WHAT COUNTRY? U S A											
13. FATHER'S NAME James P Riddle												14. MOTHER'S MAIDEN NAME Emma Loveless																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no								16. SOCIAL SECURITY NO. no								INFORMANT Eva M Riddle College Park, Maryland.								Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-intestinal bleeding 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)																								INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia																								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19								20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from Feb. 29 , 19 60 , to Mar. 12 , 19 60 that I last saw the deceased alive on Mar. 12 , 19 60 , and that death occurred at 12:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1716 K St. N.W. Washington, D.C. DATE SIGNED ACTUAL SIGNATURE Donald W. Mitchell M.D. PHYSICIAN'S NAME (Type) Dr. Donald W. Mitchell, M.D.																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial								22b. DATE THEREOF 3/15/60								22c. NAME OF CEMETERY OR CREMATORY Ammendale Cemetery								22d. LOCATION (City, town, or county) (State) Ammendale, Maryland.											
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons												ADDRESS Hyattsville, Maryland.												24a. REC'D BY REGISTRAR MAR 16 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Kram							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 3705 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03697

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 30 Fairmount Heights				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5903 L. Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Robert Middle Robinson Last Robinson				4. DATE OF DEATH Month March Day 8 Year 1960					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-7-97			
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George Robinson				14. MOTHER'S MAIDEN NAME Mildred Campbell					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.1		17. INFORMANT 998 County Road, District Helen Thomas; Heights, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-11-60			22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Arlington Va		
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington				ADDRESS 4925 1/2 Denney Ave		24a. REC'D BY REGISTRAR DATE MAR 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 3 FilmG259 3-31-60 et
 3667
 CERTIFICATE OF DEATH

03698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAPITOL HEIGHTS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>306 CAPITAL HEIGHTS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6002 H. ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hilfred First P. Middle Rogers Last</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-24-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>PETERSON</u>		16. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. <u>579-03 0152</u>	
19. INFORMANT <u>FRIEDA F JOHNSON - DAUGHTER</u>		Address	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Metastasis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)	
23. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>March 25</u> , 19 <u>60</u> , that I lost the deceased alive on <u>March 25</u> , 19 <u>60</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bernard Katzen</u> M.D.		ADDRESS (Street, city or town, state) <u>3550 - Minn. Ave - S.E.</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD KATZEN M.D.</u>		DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE THEREOF <u>3-29-60</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>PORT LINCOLN</u>		24d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>LEE FUNERAL HOME</u>		ADDRESS <u>300 HESTING</u>	
26a. REC'D BY REGISTRAR <u>DATE MAR 29 '60</u>		26b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

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[Faint, mostly illegible handwritten text, likely a death certificate form. The text is mirrored across the page, suggesting bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3773

CERTIFICATE OF DEATH

Reg. Dist. No. 03699

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE				c. LENGTH OF STAY IN 1b WASHINGTON DC 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				d. STREET ADDRESS 1414 KEARNY ST, N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LUTHER Middle (NMI) Last ROOTS				4. DATE OF DEATH Month MARCH Day 14 Year 1960			
5. SEX MALE		6. COLOR OR RACE NEGROID		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 AUGUST 1902	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BOILER FIREMAN				10b. KIND OF BUSINESS OR INDUSTRY US GOV'T EMPLOYEE		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME SOLOMON ROOTS				14. MOTHER'S MAIDEN NAME ALICE - Last name unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WW I				16. SOCIAL SECURITY NO. INFORMANT MAUDE LUTHER ROOTS Address SAME AS 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 CARDIAC ARREST DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY INSUFFICIENCY DUE TO (c) CARDIO MEGALY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 2 YRS 5 YRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 14 MARCH, 1960, to 14 MARCH, 1960, that I last saw the deceased alive on 14 MARCH, 1960, and that death occurred at 1605 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Reginald P McManus M.D. ANDREWS AIR FORCE BASE 14 MARCH 1960 PHYSICIAN'S NAME (Type) REGINALD P MC MANUS, CAPT, USAF, MC USAF HOSPITAL ANDREWS, WASHINGTON 25, D.C.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 18 MAR 60			
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL				22d. LOCATION (City, town, or county) (State) ARLINGTON VA.			
23. FUNERAL DIRECTOR'S SIGNATURE B.F. TAYLOR B. F. Taylor				24a. REC'D BY REGISTRAR DATE MAR 17 '60			
24b. REGISTRAR'S SIGNATURE Arthur L. Kneale							

UNITED STATES OF AMERICA

1933

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03700

3706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 36 West Lanham Hills			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 7742 Decatur Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Bauer Last Ross				4. DATE OF DEATH Month Mar. Day 4 Year 19 60			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-07		9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Owen Ross				14. MOTHER'S MAIDEN NAME Catherine Bauer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 321-05-8620		17. INFORMANT Address Josephine Ross; same address as # 2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Rheumatic heart disease (c) 416X DUE TO (c) 416X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/8/60		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Avenue Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE MAR 9 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. SIGNATURE OF MEDICAL EXAMINER		10. SIGNATURE OF WITNESS		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF NEXT OF KIN		15. SIGNATURE OF CLERGYMAN		16. SIGNATURE OF MINISTER	
17. SIGNATURE OF CHURCH		18. SIGNATURE OF FUNERAL HOME		19. SIGNATURE OF BURIAL PLACE		20. SIGNATURE OF INTERMENT	
21. SIGNATURE OF CEMETERY		22. SIGNATURE OF BURIAL		23. SIGNATURE OF INTERMENT		24. SIGNATURE OF CEMETERY	
25. SIGNATURE OF BURIAL		26. SIGNATURE OF INTERMENT		27. SIGNATURE OF CEMETERY		28. SIGNATURE OF BURIAL	
29. SIGNATURE OF INTERMENT		30. SIGNATURE OF CEMETERY		31. SIGNATURE OF BURIAL		32. SIGNATURE OF INTERMENT	
33. SIGNATURE OF CEMETERY		34. SIGNATURE OF BURIAL		35. SIGNATURE OF INTERMENT		36. SIGNATURE OF CEMETERY	
37. SIGNATURE OF BURIAL		38. SIGNATURE OF INTERMENT		39. SIGNATURE OF CEMETERY		40. SIGNATURE OF BURIAL	
41. SIGNATURE OF INTERMENT		42. SIGNATURE OF CEMETERY		43. SIGNATURE OF BURIAL		44. SIGNATURE OF INTERMENT	
45. SIGNATURE OF CEMETERY		46. SIGNATURE OF BURIAL		47. SIGNATURE OF INTERMENT		48. SIGNATURE OF CEMETERY	
49. SIGNATURE OF BURIAL		50. SIGNATURE OF INTERMENT		51. SIGNATURE OF CEMETERY		52. SIGNATURE OF BURIAL	
53. SIGNATURE OF INTERMENT		54. SIGNATURE OF CEMETERY		55. SIGNATURE OF BURIAL		56. SIGNATURE OF INTERMENT	
57. SIGNATURE OF CEMETERY		58. SIGNATURE OF BURIAL		59. SIGNATURE OF INTERMENT		60. SIGNATURE OF CEMETERY	
61. SIGNATURE OF BURIAL		62. SIGNATURE OF INTERMENT		63. SIGNATURE OF CEMETERY		64. SIGNATURE OF BURIAL	
65. SIGNATURE OF INTERMENT		66. SIGNATURE OF CEMETERY		67. SIGNATURE OF BURIAL		68. SIGNATURE OF INTERMENT	
69. SIGNATURE OF CEMETERY		70. SIGNATURE OF BURIAL		71. SIGNATURE OF INTERMENT		72. SIGNATURE OF CEMETERY	
73. SIGNATURE OF BURIAL		74. SIGNATURE OF INTERMENT		75. SIGNATURE OF CEMETERY		76. SIGNATURE OF BURIAL	
77. SIGNATURE OF INTERMENT		78. SIGNATURE OF CEMETERY		79. SIGNATURE OF BURIAL		80. SIGNATURE OF INTERMENT	
81. SIGNATURE OF CEMETERY		82. SIGNATURE OF BURIAL		83. SIGNATURE OF INTERMENT		84. SIGNATURE OF CEMETERY	
85. SIGNATURE OF BURIAL		86. SIGNATURE OF INTERMENT		87. SIGNATURE OF CEMETERY		88. SIGNATURE OF BURIAL	
89. SIGNATURE OF INTERMENT		90. SIGNATURE OF CEMETERY		91. SIGNATURE OF BURIAL		92. SIGNATURE OF INTERMENT	
93. SIGNATURE OF CEMETERY		94. SIGNATURE OF BURIAL		95. SIGNATURE OF INTERMENT		96. SIGNATURE OF CEMETERY	
97. SIGNATURE OF BURIAL		98. SIGNATURE OF INTERMENT		99. SIGNATURE OF CEMETERY		100. SIGNATURE OF BURIAL	
101. SIGNATURE OF INTERMENT		102. SIGNATURE OF CEMETERY		103. SIGNATURE OF BURIAL		104. SIGNATURE OF INTERMENT	
105. SIGNATURE OF CEMETERY		106. SIGNATURE OF BURIAL		107. SIGNATURE OF INTERMENT		108. SIGNATURE OF CEMETERY	
109. SIGNATURE OF BURIAL		110. SIGNATURE OF INTERMENT		111. SIGNATURE OF CEMETERY		112. SIGNATURE OF BURIAL	
113. SIGNATURE OF INTERMENT		114. SIGNATURE OF CEMETERY		115. SIGNATURE OF BURIAL		116. SIGNATURE OF INTERMENT	
117. SIGNATURE OF CEMETERY		118. SIGNATURE OF BURIAL		119. SIGNATURE OF INTERMENT		120. SIGNATURE OF CEMETERY	
121. SIGNATURE OF BURIAL		122. SIGNATURE OF INTERMENT		123. SIGNATURE OF CEMETERY		124. SIGNATURE OF BURIAL	
125. SIGNATURE OF INTERMENT		126. SIGNATURE OF CEMETERY		127. SIGNATURE OF BURIAL		128. SIGNATURE OF INTERMENT	
129. SIGNATURE OF CEMETERY		130. SIGNATURE OF BURIAL		131. SIGNATURE OF INTERMENT		132. SIGNATURE OF CEMETERY	
133. SIGNATURE OF BURIAL		134. SIGNATURE OF INTERMENT		135. SIGNATURE OF CEMETERY		136. SIGNATURE OF BURIAL	
137. SIGNATURE OF INTERMENT		138. SIGNATURE OF CEMETERY		139. SIGNATURE OF BURIAL		140. SIGNATURE OF INTERMENT	
141. SIGNATURE OF CEMETERY		142. SIGNATURE OF BURIAL		143. SIGNATURE OF INTERMENT		144. SIGNATURE OF CEMETERY	
145. SIGNATURE OF BURIAL		146. SIGNATURE OF INTERMENT		147. SIGNATURE OF CEMETERY		148. SIGNATURE OF BURIAL	
149. SIGNATURE OF INTERMENT		150. SIGNATURE OF CEMETERY		151. SIGNATURE OF BURIAL		152. SIGNATURE OF INTERMENT	
153. SIGNATURE OF CEMETERY		154. SIGNATURE OF BURIAL		155. SIGNATURE OF INTERMENT		156. SIGNATURE OF CEMETERY	
157. SIGNATURE OF BURIAL		158. SIGNATURE OF INTERMENT		159. SIGNATURE OF CEMETERY		160. SIGNATURE OF BURIAL	
161. SIGNATURE OF INTERMENT		162. SIGNATURE OF CEMETERY		163. SIGNATURE OF BURIAL		164. SIGNATURE OF INTERMENT	
165. SIGNATURE OF CEMETERY		166. SIGNATURE OF BURIAL		167. SIGNATURE OF INTERMENT		168. SIGNATURE OF CEMETERY	
169. SIGNATURE OF BURIAL		170. SIGNATURE OF INTERMENT		171. SIGNATURE OF CEMETERY		172. SIGNATURE OF BURIAL	
173. SIGNATURE OF INTERMENT		174. SIGNATURE OF CEMETERY		175. SIGNATURE OF BURIAL		176. SIGNATURE OF INTERMENT	
177. SIGNATURE OF CEMETERY		178. SIGNATURE OF BURIAL		179. SIGNATURE OF INTERMENT		180. SIGNATURE OF CEMETERY	
181. SIGNATURE OF BURIAL		182. SIGNATURE OF INTERMENT		183. SIGNATURE OF CEMETERY		184. SIGNATURE OF BURIAL	
185. SIGNATURE OF INTERMENT		186. SIGNATURE OF CEMETERY		187. SIGNATURE OF BURIAL		188. SIGNATURE OF INTERMENT	
189. SIGNATURE OF CEMETERY		190. SIGNATURE OF BURIAL		191. SIGNATURE OF INTERMENT		192. SIGNATURE OF CEMETERY	
193. SIGNATURE OF BURIAL		194. SIGNATURE OF INTERMENT		195. SIGNATURE OF CEMETERY		196. SIGNATURE OF BURIAL	
197. SIGNATURE OF INTERMENT		198. SIGNATURE OF CEMETERY		199. SIGNATURE OF BURIAL		200. SIGNATURE OF INTERMENT	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03701

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb D.O.A.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital				d. STREET ADDRESS 5809 Arbor Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Louis Middle Arthur Last Scheidt				4. DATE OF DEATH Month March Day 3rd Year 1960			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-6-91	
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY W.S.San. Comm.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry A. Scheidt				14. MOTHER'S MAIDEN NAME Johanna Becker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 219-05-4819		17. INFORMANT Elizabeth Scheidt; same address as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c) _____</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney				DATE SIGNED March 3, 1960			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL Specify Burial		22b. DATE THEREOF 3-7-1960		22c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR MAR 7 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the time by filing this certificate with the Registrar. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be retained by the Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

03702

3774

1. PLACE OF DEATH o. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearview		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clearview	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10--Delano Dr.		d. STREET ADDRESS 10--Delano Dr.	
3. NAME OF DECEASED (Type or print) First MARIAM Middle C. Last SCHWENK		4. DATE OF DEATH Month Mar. Day 19th Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Apr. 1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Richardson		14. MOTHER'S MAIDEN NAME Rachael Pyles	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Margaret N. Zsoldos 10 Delano Dr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Acute myocardial Deconjugation DUE TO (b) General Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 1 hour unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none of note			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) natural Causes	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 4, 1956, to March 19, 1960 that I last saw the deceased alive on March 18, 1960 and that death occurred at 10:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Paul C. Van Natta		M.D. 5440 Silver Hill Rd., S.E. 3-20-60	
PHYSICIAN'S NAME (Type) Dr. Paul C. Van Natta		5440- Silver Hill Rd., S.E. Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 23 Mar 1960	22c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery	22d. LOCATION (City, town, or county) (State) Washington, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros Funeral Home		24a. REC'D BY REGISTRAR 1601--Good Hope Rd SE Washington DC DATE MAR 21 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

CERTIFICATE OF DEATH

3734

Location

Residence of

Place of

Age

Sex

Occupation

Signature

Date

Time

Place

Signature

Date

Time

Place

Signature

Date

Time

Place

Signature

Date

Time

Place

Signature

Date

Time

Place

Signature

Date

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3708

CERTIFICATE OF DEATH

Reg. Dist. No.

03703

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 23 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 42 E. Ridge Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Oswald Semore Smith				4. DATE OF DEATH Month Day Year March 15 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 15 1895	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10b. KIND OF BUSINESS OR INDUSTRY Heating		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Richard Smith				14. MOTHER'S MAIDEN NAME Jennie Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. INFORMANT Address Elmer Smith Hyattsville, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X Uremia DUE TO (b) Pyelonephritis, acute + chronic DUE TO (c) Prostatic hypertrophy, benign CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> ① Suspical absence of right kidney ② Acute pericarditis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-15-60, to 3-15-60, that I last saw the deceased alive on 3-15-60, and that death occurred at 1:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William C. Weintraub M.D. 9 E Parkway, Greenbelt, Md 3-15-60 PHYSICIAN'S NAME (Type) William C Weintraub 9 E Parkway Greenbelt, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF March 18, 1960			
22c. NAME OF CEMETERY OR CREMATION George Washington				22d. LOCATION (City, town, or county) (State) Hyattsville, Maryland.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.			
24a. REC'D BY REGISTRAR DATE MAR 17 '60				24b. REGISTRAR'S SIGNATURE Arthur L. House			

1078

RECEIVED

1078

TO THE
HONORABLE
MEMBERS OF THE
LEGISLATIVE
COUNCIL
OF THE
STATE OF
VIRGINIA
AT THE
ANNUAL
SESSION
Held at
Richmond
January 15th
1907

REPORT
OF THE
COMMISSIONER
OF THE
LAND OFFICE
IN RESPONSE
TO A RESOLUTION
PASSED BY THE
LEGISLATIVE
COUNCIL
AT ITS
ANNUAL
SESSION
Held at
Richmond
January 15th
1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8,28, Film 2250 3/24/60 1b

CERTIFICATE OF DEATH

Reg. Dist. No.

03704

3734

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel c. LENGTH OF STAY IN TB Laurel General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 345 d. STREET ADDRESS Jessup e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Maggie Stempler		4. DATE OF DEATH Month Day Year March 15 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2, 1881
9. AGE (In years last birthday) 78-79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Redmiles	
14. MOTHER'S MAIDEN NAME Mary Carrott		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. Hospital Records		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diverticulosis and Diverticulitis of sigmoid colon; many years. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease, with cardiomegaly			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Laurel, Md.		20g. (County) Howard	
20h. (State) Md.		20i. (Country) U.S.A.	
21. I certify that I attended the deceased from 28 February, 1960 , to 15 March, 1960 , that I last saw the deceased alive on 14 March, 1960 , and that death occurred at 1:35 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Richard Compton		DATE SIGNED 15 March 1960	
PHYSICIAN'S NAME (Type) J. Richard Compton M.D. 612 Main Street, Laurel, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)	
22e. (State)		22f. (Country)	
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Higinbotham			
ADDRESS 106 Columbia Rd., Ellicott City, Md.			
24a. REC'D BY REGISTRAR MAR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur J. Francis	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

3710

CERTIFICATE OF DEATH

Reg. Dist. No.

03706

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle Stewart Last Stewart		4. DATE OF DEATH Month Mar. Day 18 Year 1960	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY md.	11. BIRTHPLACE (State or foreign country) U. S. A.
13. FATHER'S NAME Patrick Stewart		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Edith Sterens - Upper Marlboro	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 18, 1960 , to Mar. 18, 1960 that I last saw the deceased alive on Mar. 18, 1960 , and that death occurred at 5:20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE D. S. Clayman		ADDRESS (Street, city or town, state) 6311 Belts to Road, Md.	
PHYSICIAN'S NAME (Type) _____		DATE SIGNED 3/18/60	
22a. BURIAL CREMATION, REMOVAL (Specify) 3-21-60	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Holy Family Cn.	22d. LOCATION (City, town, or county) (State) Woodmore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry Washington ADDRESS 4925 Dean Ave NE		24a. REC'D BY REGISTRAR MAR 22 '60	
		24b. REGISTRAR'S SIGNATURE Charles S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03705

3709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bowie	
3. NAME OF DECEASED (Type or print) First Middle Last William Pinkney Steward		4. DATE OF DEATH Month Day Year March 11 1960	
5. SEX Male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-88
9. AGE (in years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Ella Steward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Emily Moore; Bowie, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular renal disease (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute catarrhal fever			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John J. Maloney		DATE SIGNED	
EXAMINER'S NAME (Type) John T. Maloney, M.D.		March 11, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-14-60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines & Company Funeral Home		24a. REC'D BY REGISTRAR	
ADDRESS 3015 12th St., N. E.		DATE March 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

ARMY AND NAVY DEPARTMENT - BATHING
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1203

1. NAME OF DECEASED		2. GRADE OR RATE	
3. SERVICE NUMBER		4. DATE OF DEATH	
5. PLACE OF DEATH		6. CAUSE OF DEATH	
7. DISEASE OR INJURY		8. MEDICAL HISTORY	
9. PHYSICAL EXAMINATION		10. MENTAL EXAMINATION	
11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESSES	
13. DATE OF EXAMINATION		14. PLACE OF EXAMINATION	
15. NAME OF HOSPITAL		16. NAME OF PHYSICIAN	
17. NAME OF NURSE		18. NAME OF ATTENDING PHYSICIAN	
19. NAME OF SURGEON		20. NAME OF DENTIST	
21. NAME OF PATHOLOGIST		22. NAME OF RADIOLOGIST	
23. NAME OF ANATOMIST		24. NAME OF HISTOLOGIST	
25. NAME OF MICROSCOPIST		26. NAME OF PHARMACEUTICIST	
27. NAME OF CHEMIST		28. NAME OF PHYSICIAN	
29. NAME OF NURSE		30. NAME OF ATTENDING PHYSICIAN	
31. NAME OF SURGEON		32. NAME OF DENTIST	
33. NAME OF PATHOLOGIST		34. NAME OF RADIOLOGIST	
35. NAME OF ANATOMIST		36. NAME OF HISTOLOGIST	
37. NAME OF MICROSCOPIST		38. NAME OF PHARMACEUTICIST	
39. NAME OF CHEMIST		40. NAME OF PHYSICIAN	
41. NAME OF NURSE		42. NAME OF ATTENDING PHYSICIAN	
43. NAME OF SURGEON		44. NAME OF DENTIST	
45. NAME OF PATHOLOGIST		46. NAME OF RADIOLOGIST	
47. NAME OF ANATOMIST		48. NAME OF HISTOLOGIST	
49. NAME OF MICROSCOPIST		50. NAME OF PHARMACEUTICIST	
51. NAME OF CHEMIST		52. NAME OF PHYSICIAN	
53. NAME OF NURSE		54. NAME OF ATTENDING PHYSICIAN	
55. NAME OF SURGEON		56. NAME OF DENTIST	
57. NAME OF PATHOLOGIST		58. NAME OF RADIOLOGIST	
59. NAME OF ANATOMIST		60. NAME OF HISTOLOGIST	
61. NAME OF MICROSCOPIST		62. NAME OF PHARMACEUTICIST	
63. NAME OF CHEMIST		64. NAME OF PHYSICIAN	
65. NAME OF NURSE		66. NAME OF ATTENDING PHYSICIAN	
67. NAME OF SURGEON		68. NAME OF DENTIST	
69. NAME OF PATHOLOGIST		70. NAME OF RADIOLOGIST	
71. NAME OF ANATOMIST		72. NAME OF HISTOLOGIST	
73. NAME OF MICROSCOPIST		74. NAME OF PHARMACEUTICIST	
75. NAME OF CHEMIST		76. NAME OF PHYSICIAN	
77. NAME OF NURSE		78. NAME OF ATTENDING PHYSICIAN	
79. NAME OF SURGEON		80. NAME OF DENTIST	
81. NAME OF PATHOLOGIST		82. NAME OF RADIOLOGIST	
83. NAME OF ANATOMIST		84. NAME OF HISTOLOGIST	
85. NAME OF MICROSCOPIST		86. NAME OF PHARMACEUTICIST	
87. NAME OF CHEMIST		88. NAME OF PHYSICIAN	
89. NAME OF NURSE		90. NAME OF ATTENDING PHYSICIAN	
91. NAME OF SURGEON		92. NAME OF DENTIST	
93. NAME OF PATHOLOGIST		94. NAME OF RADIOLOGIST	
95. NAME OF ANATOMIST		96. NAME OF HISTOLOGIST	
97. NAME OF MICROSCOPIST		98. NAME OF PHARMACEUTICIST	
99. NAME OF CHEMIST		100. NAME OF PHYSICIAN	

3711

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle L. Last Sweeney				4. DATE OF DEATH Month March Day 27 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-7-16		9. AGE (In years last birthday) 43 yrs.	10. IF UNDER 1 YEAR Months 10 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 1st MAINTAINER				10b. KIND OF BUSINESS OR INDUSTRY WASHINGTON TERMINAL		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES SWEENEY				14. MOTHER'S MAIDEN NAME AGNES HOLMES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 577-10-3102			
17. INFORMANT CLARANELLE E. SWEENEY				Address 5418 GALLATIN ST ROGER HGTS, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 592x DUE TO CHRONIC GLOMERULAR NEPHRITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 YEAR DUE TO (c) 10 DAYS				INTERVAL BETWEEN ONSET AND DEATH 10 DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from MAR 15, 1960 to MAR 27, 1960 that I last saw the deceased alive on MAR 27, 1960 , and that death occurred at 2:25 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. Sugar M.D.				ADDRESS (Street, city or town, state) 4300 RAYWOOD DR DATE SIGNED 3/27/60			
PHYSICIAN'S NAME (Type) Dr. S. Sugar				MT RAINIER, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3-31-60		22c. NAME OF CEMETERY OR CREMATORY SAMPLES MANOR CEM	
22d. LOCATION (City, town, or county) (State) PLEASANT VALLEY, MD.							
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS CO.,				ADDRESS Riverdale, Maryland		24a. REC'D BY REGISTRAR MAR 29 '60	
24b. REGISTRAR'S SIGNATURE Arthur J. Hanna							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALMASU

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN tb 21 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS Main St. (Rt. 4) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas I. Talbott		4. DATE OF DEATH Month March Day 14 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 17, 1885
9. AGE (In years last birthday) 74 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith 10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Henry Talbott		14. MOTHER'S MAIDEN NAME Laura Elizabeth Wells	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --- INFORMANT Myrtie Jarboe Talbott-Same as above. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 26, 1960 to Mar 14, 1960 that I last saw the deceased alive on Mar 14, 1960 , and that death occurred at 2:55 PM , from the causes and on the date stated above. ADDRESS (Street, City or town, state) 1746 R 3020 DATE SIGNED 3/14/60 ACTUAL SIGNATURE Donald W. Mitchell PHYSICIAN'S NAME (Type) Dr. Donald W. Mitchell, M.D. Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/17/60	22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Upper Marlboro, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home - Upper Marlboro, Md.		24a. REC'D BY REGISTRAR DATE MAR 18 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

3713

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 3 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Alma Middle B. Last Tayman			4. DATE OF DEATH Month Mar. Day 4 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 20, 1879		9. AGE (In years lost birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME William R. Smallwood		
14. MOTHER'S MAIDEN NAME Kate Duley			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. -----			17. INFORMANT William H. Tayman-Same as above.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-Vascular DUE TO Brain Tumor (c) 524					INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Breast with metastasis to Lung					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from Jan 15 , 19 60 , to Mar 4 , 19 60 , that I last saw the deceased alive on Mar 3 , 19 60 , and that death occurred at 5:30 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. Sasser		M.D. Upper Marlboro, Md.		ADDRESS (Street, city or town, state) Upper Marlboro, Md.	
PHYSICIAN'S NAME (Type) Dr. James Sasser, M.D.		DATE SIGNED Mar 18 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/7/60		22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	
22d. LOCATION (City, town, or county) Groom		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home		ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR Mar 18 1960	
24b. REGISTRAR'S SIGNATURE Arthur S. Harris					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

To be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3714 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Melvin Middle C. Last Tayman				4. DATE OF DEATH Month March Day 23 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 July 1903	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Charles O. Tayman		14. MOTHER'S MAIDEN NAME Rosa Seaborn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-10-7709		INFORMANT Eleanor L. Tayman		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 022 x Refracted Aortic Aneurysm DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4 , 19 49 , to 3-23 , 19 60 , that I last saw the deceased alive on 3-23 , 19 60 , and that death occurred at 8, 31 M from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. A. Deitz, M.D.		M.D. Hyattsville, Md		ADDRESS (Street, city or town, state) Hyattsville, Md		DATE SIGNED 3-24-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Ave. Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
				24b. REGISTRAR'S SIGNATURE William S. Kinn			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3714

1-10-1900

John D. ...

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CERTIFICATE OF DEATH

Reg. Dist. No.

3715

1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesley, Md				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville,			
d. NAME OF HOSPITAL (If not in hospital, give street address) Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Florence Tippet				4. DATE OF DEATH Month March Day 26 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/24/27	
9. AGE (In years lost birthday) 32 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Fairfax Bradshaw				14. MOTHER'S MAIDEN NAME Jennie Brown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca of Cervix DUE TO (c) metastatic				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from MARCH 26, 1960 , to MARCH 26, 1960 that I last saw the deceased alive on MARCH 26, 1960 , and that death occurred at 9:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE D. Clayman				ADDRESS (Street, city or town, state) 6311 Beeto Cir, Reardon Md			
PHYSICIAN'S NAME (Type) Dr. D. Clayman				DATE SIGNED 3/27/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/60		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Waldorf Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Upper Marlboro, Md.				24a. REC'D BY REGISTRAR APR 18 '60		24b. REGISTRAR'S SIGNATURE C. L. G. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17/4

3716

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beltsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		d. STREET ADDRESS 6130 Murkirk Rd/	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Toliver, Irvin		4. DATE OF DEATH March 19 1960	
5. SEX Male	6. COLOR OR RACE Black	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1896
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY humber	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME William Toliver		14. MOTHER'S MAIDEN NAME Mildred Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address Mrs Mary Smith Beltsville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO chemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis, acute + chronic DUE TO (c) Blanchopneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2 Cerebellar hemorrhages			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MARCH 12, 1960 , to MARCH 19, 1960 , that I last saw the deceased alive on MARCH 18, 1960 , and that death occurred at 7:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David S. Clayman M.D.		ADDRESS (Street, city or town, state) 6311 Beltsville Road Md DATE SIGNED 3/20/60	
PHYSICIAN'S NAME (Type) Dr. David S. Clayman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-24-60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Queens Chapel		22d. LOCATION (City, town, or county) (State) Murphy Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry S. Washington ADDRESS 4825 Dean Ave 775		24a. REC'D BY REGISTRAR MAR 28 '60 DATE	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2, 14 Film G260 4-5-60 et

3663 CERTIFICATE OF DEATH

03712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>H Gaithersburg</u> c. LENGTH OF STAY IN 1b <u>2 no 4 day</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6403 Ager Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> D. C. b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>2200 California St NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Angella</u> Middle <u>Marie</u> Last <u>Trombetti</u>				4. DATE OF DEATH Month <u>3</u> Day <u>30</u> Year <u>1960</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/30/59</u>		9. AGE (In years lost birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>30</u> Hours <u>19</u> Min. <u>60</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>infant</u>		11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Not known</u>				14. MOTHER'S MAIDEN NAME <u>Marie Josephine Trombetti (no address)</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>History in nursing home</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>internal by chocephalus - (had encephalus 33%)</u> DUE TO <u>752X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>respiratory paralysis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/26</u> , 19 <u>60</u> , to <u>3/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/30</u> , 19 <u>60</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <u>Thomas A. Christensen</u> M.D. <u>6905 B&O Blvd</u>						ADDRESS (Street, city or town, state) <u>College Park, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>Thomas A. Christensen</u>						DATE SIGNED <u>3/30/60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Mar 31-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Reginald Walsh</u>						ADDRESS <u>741-11-11 St.</u>					
24a. REC'D BY REGISTRAR <u>APR 1 '60</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3883

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>	
5. PLACE OF BIRTH <i>St. Louis, Mo.</i>		6. OCCUPATION <i>Engineer</i>	
7. MARITAL STATUS <i>Married</i>		8. DATE OF MARRIAGE <i>June 10 1925</i>	
9. NAME OF SPOUSE <i>Elizabeth A. Smith</i>		10. PLACE OF MARRIAGE <i>St. Louis, Mo.</i>	
11. DATE OF DEATH <i>Dec 10 1945</i>		12. TIME OF DEATH <i>10:30 AM</i>	
13. PLACE OF DEATH <i>Home</i>		14. CAUSE OF DEATH <i>Heart Disease</i>	
15. DISEASE OR INJURY <i>Coronary Artery Disease</i>		16. IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i>	
17. UNDERLYING CAUSE OF DEATH <i>Coronary Artery Disease</i>		18. MANNER OF DEATH <i>Natural</i>	
19. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		20. SIGNATURE OF WITNESSES <i>Dr. J. H. Jones, Dr. A. B. White</i>	
21. SIGNATURE OF DECEASED <i>John A. Smith</i>		22. SIGNATURE OF SPOUSE <i>Elizabeth A. Smith</i>	
23. SIGNATURE OF CHILD <i>Robert A. Smith</i>		24. SIGNATURE OF PARENT <i>John A. Smith</i>	
25. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		26. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
27. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		28. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
29. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		30. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
31. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		32. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
33. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		34. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
35. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		36. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
37. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		38. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
39. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		40. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
41. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		42. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
43. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		44. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
45. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		46. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
47. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		48. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
49. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		50. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
51. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		52. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
53. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		54. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
55. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		56. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
57. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		58. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
59. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		60. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
61. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		62. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
63. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		64. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
65. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		66. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
67. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		68. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
69. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		70. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
71. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		72. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
73. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		74. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
75. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		76. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
77. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		78. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
79. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		80. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
81. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		82. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
83. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		84. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
85. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		86. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
87. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		88. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
89. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		90. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
91. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		92. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
93. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		94. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	
95. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>		96. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>	
97. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>		98. SIGNATURE OF OTHER RELATIVE <i>Robert A. Smith</i>	
99. SIGNATURE OF OTHER RELATIVE <i>John A. Smith</i>		100. SIGNATURE OF OTHER RELATIVE <i>Elizabeth A. Smith</i>	

RECEIVED
BALTIMORE
DECEMBER 11 1945

3775 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Ruth</u> First <u>Ophelia</u> Middle <u>Underwood</u> Last		4. DATE OF DEATH <u>March</u> Month <u>2</u> Day <u>1960</u> Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 24 1878</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Bagot</u>		14. MOTHER'S MAIDEN NAME <u>ELLIZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Robert Smith, Accokeek, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC FAILURE</u> DUE TO <u>260X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>OCCCLUSION OF LEFT FEMORAL ART.</u> (c) <u>DIABETES MELLITUS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>2 mos.</u> <u>YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 1ST, 1957</u> to <u>MAR 22D, 1960</u> , that I last saw the deceased alive on <u>MAR 22D, 1960</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Chen</u>		ADDRESS (Street, city or town, state) <u>Accokeek, MD</u>	
PHYSICIAN'S NAME (Type) <u>PAUL CHEN</u>		DATE SIGNED <u>MAR 22nd, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>Accokeek, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of the certificate should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 of the certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

James George
Maryland
Accokeek

James George
Accokeek

Age 60
March 2
Ophelia Underwood
F. W.
Horsecock
William Badet
None Mrs Robert Smith, Accokeek, Md

James George
Accokeek, Md

18
FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3717

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03714

1. PLACE OF DEATH e. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 FORESTVILLE d. STREET ADDRESS 13706 79th AVE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVERLY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PR. GEO. GENERAL HOSPITAL							
3. NAME OF DECEASED (Type or print) FRANK		First Middle Last UNSWORTH		4. DATE OF DEATH MAR 24 1960		Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 5 1924	9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) APPRENTICE PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM UNSWORTH		14. MOTHER'S MAIDEN NAME JENNIE SCHAEFER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 577-26-9783		17. INFORMANT MRS FRANCES B. UNSWORTH Address 3706 79th AVE FORESTVILLE, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-16 X acute congestive heart failure DUE TO (b) Rheumatic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James T. Boyd M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JAMES T. BOYD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) March 24-1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-28-60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Suitland, Md	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md.				24a. REC'D BY REGISTRAR MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

10710

MEDICAL EXAMINER CERTIFICATE OF DEATH

3710

IN THE CITY OF NEW YORK

DECEASED

18-11-1910

18-11-1910

18-11-1910

18-11-1910

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18-11-1910

3776

CERTIFICATE OF DEATH

03715

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Pro George's County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Pro Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) South Cheverly, Md.		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 South Cheverly Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3516 56th Place				d. STREET ADDRESS 1 3516 56th Place		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emily Middle Marie Last Vedel				4. DATE OF DEATH Month Ma rch 28 , 19 60			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 10, 1873	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Victor Comb				14. MOTHER'S MAIDEN NAME Marie Louise Seuzaret			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address W D De Long South Cheverly, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Chn myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) Arterio sclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) no						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no					
20c. TIME OF INJURY Month, Day, Year Hour o. m. no 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1960 , to May 28, 1960 , that I last saw the deceased alive on May 28, 1960 , and that death occurred at 8:40 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE AK BOWIE		DATE SIGNED 3/28/60					
PHYSICIAN'S NAME (Type) AK BOWIE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Transportation 3/28/60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Topeka		22d. LOCATION (City, town, or county) (State) Kansas	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Maryland.				24a. REC'D BY REGISTRAR DATE MAR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1933

CERTIFICATE OF DEATH

3775

State of New York
County of New York
City of New York
I, the undersigned, being a duly qualified medical officer of health for the City and County of New York, do hereby certify that
the within and foregoing is a true and correct copy of the original record of death as the same appears from the files of the Department of Health of the City and County of New York.
Witness my hand and the seal of the Department of Health of the City and County of New York, this _____ day of _____, 19____.

Signature of Medical Officer of Health
Name of Medical Officer of Health
Title of Medical Officer of Health
Department of Health of the City and County of New York
City of New York
County of New York
State of New York

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03716

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillside</u>		c. LENGTH OF STAY IN 1b <u>8 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Hillside</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5900 M Street</u>				d. STREET ADDRESS <u>5900 M Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Elmo</u> Last <u>Waldron</u>				4. DATE OF DEATH Month <u>March</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 13, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinet Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u> Lynchburg, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. - S</u>				13. FATHER'S NAME <u>Samuel S. Waldron</u>			
14. MOTHER'S MAIDEN NAME <u>Mathe Alice Pleasant</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>no</u>			
16. SOCIAL SECURITY NO. <u>226-01-8594</u>				17. INFORMANT <u>Cecile Waldron, Address #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/10/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. - 2901 14th St. N.W. Washington 9, D.C.</u>			
24a. REC'D BY REGISTRAR <u>MAR 10 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]	
SIGNATURE OF MEDICAL EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	
ADDRESS OF DECEASED [Faint text]		ADDRESS OF MEDICAL EXAMINER [Faint text]		ADDRESS OF WITNESS [Faint text]	
CITY [Faint text]		COUNTY [Faint text]		STATE [Faint text]	
ZIP CODE [Faint text]		MEDICAL EXAMINER'S LICENSE NO. [Faint text]		WITNESS'S LICENSE NO. [Faint text]	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH [Faint text]		WITNESS'S CERTIFICATE OF DEATH [Faint text]		DECEASED'S CERTIFICATE OF DEATH [Faint text]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3778

CERTIFICATE OF DEATH

Reg. Dist. No.

03717

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE D. C. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 3321 O. St., N. W. (?)			
3. NAME OF DECEASED (Type or print) First Middle Last Wyan W. Walker				4. DATE OF DEATH Month Day Year 3 15 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> but separated	8. DATE OF BIRTH 1/5/93	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Oklahoma	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. -		INFORMANT Address D. C. General Hospital Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of the liver 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Chronic alcoholism; 2) Generalized arteriosclerosis; 3) Ascites INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/7, 19 60, to 3/15, 19 60, that I lost s/he the deceased alive on 3/15, 19 60, and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED M.D. Glenn Dale Hospital 3/15/60 ACTUAL SIGNATURE Moe Weiss PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/15/60		22c. NAME OF CEMETERY OR CREMATORY D. C. George		22d. LOCATION (City, town, or county) (State) Washington D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Glenn Dale, Md.				24a. REG. BY REGISTRAR DATE MAR 18 60		24b. REGISTRAR'S SIGNATURE	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

3775

TO " TO

VS A15 (4)
15M 9/55

3779

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLINTON</u>				c. LENGTH OF STAY IN lb <u>8 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 3 Box 682</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IVANOV</u> <u>NELLIE</u> <u>WARD</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>27</u> <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 9, 1904</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>BROOKFIELD, N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>CHARLES WRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>EMOGENE PARKHURST</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>HUSBAND FLOYD WARD</u> Address <u>RT 3 Box 682 CLINTON, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> <u>151X</u> DUE TO <u>GENERALIZED CARCINOMATOSIS</u> 7 MDS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF STOMACH</u> 10 MDS. (c) <u>NONE</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <u>NONE</u>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>							
20c. TIME OF INJURY Month, Day, Year Hour of day <u>NONE</u> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u>				20f. (City or town) (County) (State) <u>NONE</u>			
21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>59</u> , to <u>PRESENT</u> , that I last saw the deceased alive on <u>MARCH 26</u> , 19 <u>60</u> , and that death occurred at <u>238</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Arthur Shaver Jr. M.D. Branch Ave. Clinton, Md. 3/27/60</u>							
ACTUAL SIGNATURE <u>Arthur Shaver Jr. M.D.</u> M.D. <u>Branch Ave. Clinton, Md. 3/27/60</u>							
PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON, MD. 3/27/60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>3/30/60</u>		<u>Cedar Hill</u>		<u>Suittland md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. 517 11th St. S.E.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 29 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be attached for use as the burial-transit permit. It should be attached to the certificate for burial, cremation, or removal, and in any event, it should be retained by the funeral director.

certificate be executed by

hours after death: Page 4

ing physician and completed by the funeral director, remove carbon papers. Pages 1 and 2 should be filed with the certificate 72 hours after death.

3742

CERTIFICATE OF DEATH

Reg. Dist. No.

03719

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>14 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>Warren</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>March</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-23-36</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>National Security Agency U S Govt.</u>		9. AGE (In years last birthday) <u>23</u> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>	
13. FATHER'S NAME <u>Virgil H Warren Sr</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. MOTHER'S MAIDEN NAME <u>Rose Moraine</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give War or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Record</u> Address	

J. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Diabetic acidosis
260X DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
 (b) Diabetes Mellitus DUE TO
 (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3-28, 1960, to 3-28, 1960, that I last saw the deceased alive on 3-28, 1960, and that death occurred at 4:10 M, from the causes and on the date stated above.

ACTUAL SIGNATURE D. R. Purdie M.D. ADDRESS (Street, city or town, state) Riverdale Md DATE SIGNED March 28, 1960
 PHYSICIAN'S NAME (Type) D R Purdie Riverdale Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hollywood California</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>Apr 1 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Krum</u>

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03720

3718

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 20 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Watkins				4. DATE OF DEATH Month Day Year Mar. 15 19 60			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23 1913	
9. AGE (In years last birthday) 46 yrs.		10. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Hospital			
13. FATHER'S NAME John H. Gudger				14. MOTHER'S MAIDEN NAME Julia Lancaster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Bertha Justice				Address 1323 Dexter Terr. S.E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 197.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sarcinomatosis DUE TO (c) Leiomyosarcoma of retroperitoneal space							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19				20g. (County) 19		20h. (State) 19	
21. I certify that I attended the deceased from Feb. 24 , 19 60 , to Mar. 15 , 19 60 that I last saw the deceased alive on Mar. 15 , 19 60 , and that death occurred at 7:15 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. David S. Clayman				ADDRESS (Street, city or town, state) 6311 Baltimore Riverdale			
PHYSICIAN'S NAME (Type) Dr. David S. Clayman, M.D.				DATE SIGNED 3/15/60			
22a. BURIAL CREMATION, REMOVAL (Specify) 3-21-60				22b. DATE THEREOF 3-21-60		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) 74 Myer				22e. (State) 74		22f. (State) 74	
23. FUNERAL DIRECTOR'S SIGNATURE Nozima's Funeral Home				ADDRESS 389 Rhode Island Ave		24a. REC'D BY REGISTRAR MAR 17 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Smith				DATE MAR 17 '60		24c. REGISTRAR'S SIGNATURE Arthur S. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

03721

3719

1. PLACE OF DEATH o. COUNTY Prince Georges County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesverly				c. LENGTH OF STAY IN lb 14 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Dora Middle Webster Last Webster				4. DATE OF DEATH Month March Day 20 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/2/1889	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 71 Days 71 Hours 71 Min.		IF UNDER 24 HRS. Months 71 Days 71 Hours 71 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Washington D. C.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Wallace Bassford				14. MOTHER'S MAIDEN NAME Unk.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
INFORMANT Alfred J. Webster				Address Same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. ANEMIA DUE TO 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 2. PYELONEPHRITIS, CHRONIC DUE TO 5 YEARS (c) 15 DAYS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio Vascular Disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 3/20 , 19 54 , to 3/20 , 19 60 , that I last saw the deceased alive on 3/20 , 19 60 , and that death occurred at 7:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Norman Donat Comcau				ADDRESS (Street, city or town, state) 3503 Penny St			
PHYSICIAN'S NAME (Type) NORMAN DONAT COMCAU				DATE SIGNED 3/20/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/23/60			
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln				22d. LOCATION (City, town, or county) (State) Colmar Manor Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				4739 Baltimore Ave. Hyattsville, Md.			
24a. REC'D BY REGISTRAR MAR 22 '60				24b. REGISTRAR'S SIGNATURE Carlton S. Hunt			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3718

Private Property

Private Property

Private Property

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CERTIFICATE OF DEATH

Reg. Dist. No.

04924

3720

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General				d. STREET ADDRESS School Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Welch				4. DATE OF DEATH Month March Day 25 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-13-60	
9. AGE (In years last birthday) 12 yrs.		IF UNDER 1 YEAR Months 12 Days 12 Hours 12 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William S Welch Jr.				14. MOTHER'S MAIDEN NAME Dortha Mae Rise			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro-enteritis 764.5 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity							
INTERVAL BETWEEN ONSET AND DEATH 72 hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 13, 1960 , to March 25, 1960 , that I lost s/he the deceased alive on March 25, 1960 , and that death occurred at 5:35 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert J. Friedel M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 4/1/60			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 4/6/60		22c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital, Cheverly, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry W. Penn, Jr. ADDRESS Administrator.				24a. RECEIVED BY REGISTRAR APR 11 1960 DATE		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Source: *Author's calculations*.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3743

CERTIFICATE OF DEATH

Reg. Dist. No.

03722

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, MD.</u>				c. LENGTH OF STAY IN 1b <u>15 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Chererly</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Land Memorial Hosp</u>				d. STREET ADDRESS <u>3306 Bellview Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Howard</u> Last <u>Wells</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 25, 1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Warren Dewey Wells</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Clark</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give part or dates of service) <u>World War I</u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Mrs Lucille Wells</u> Address <u>3306 Bellview Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Myocardial Infarction</u> <u>420.1</u> DUE TO (b) <u>Car.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Descending Colon</u>							
INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>25 Feb</u> , 19 <u>60</u> , to <u>16 March</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>16 March</u> , 19 <u>60</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John M. Hutchins</u>				ADDRESS (Street, city or town, state) <u>7315 Landover Rd.</u>			
PHYSICIAN'S NAME (Type) <u>T.M. Hutchins</u>				DATE SIGNED <u>3-17-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				4739 Baltimore Avenue <u>Hyattsville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF BIRTH <i>Jan 15 1900</i>		5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. OCCUPATION <i>Teacher</i>	
7. MARITAL STATUS <i>Married</i>		8. NAME OF SPOUSE <i>Jane Doe</i>		9. DATE OF MARRIAGE <i>Jan 1 1920</i>		10. PLACE OF MARRIAGE <i>Baltimore, Md.</i>		11. DEGREE OF EDUCATION <i>High School</i>		12. PRESENT ADDRESS <i>123 Main St, Baltimore, Md.</i>	
13. CAUSE OF DEATH <i>Heart Disease</i>		14. DURATION OF ILLNESS <i>2 weeks</i>		15. DATE OF DEATH <i>Mar 10 1945</i>		16. TIME OF DEATH <i>10:00 AM</i>		17. PLACE OF DEATH <i>Home</i>		18. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>Jane Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>Jane Doe</i>		23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>Jane Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>Jane Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>Jane Doe</i>		29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>Jane Doe</i>	

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY A PHYSICIAN OR A JUDGE OF THE DISTRICT COURT. IT IS VOID IF SIGNED BY ANY OTHER PERSON. IT IS VOID IF SIGNED BY A PHYSICIAN WHO IS NOT A MEMBER OF THE MARYLAND MEDICAL ASSOCIATION. IT IS VOID IF SIGNED BY A JUDGE WHO IS NOT A MEMBER OF THE JUDICIAL BRANCH OF THE MARYLAND JUDICIAL SYSTEM. IT IS VOID IF SIGNED BY A PHYSICIAN WHO IS NOT A MEMBER OF THE MARYLAND MEDICAL ASSOCIATION. IT IS VOID IF SIGNED BY A JUDGE WHO IS NOT A MEMBER OF THE JUDICIAL BRANCH OF THE MARYLAND JUDICIAL SYSTEM.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3744 CERTIFICATE OF DEATH

Reg. Dist. No.

03723

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 64 University Park, Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) Eugene Leland Memorial Hospital		d. STREET ADDRESS 4400 Tuckerman St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle SUSAN Last WHEATLEY		4. DATE OF DEATH Month March Day 3 Year 19 60	
5. SEX female	6. COLOR OR RACE cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/20/59
9. AGE (In years last birthday) yrs. 6 Months 12 Days 12 Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Riverdale, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Albert Paul Wheatley		14. MOTHER'S MAIDEN NAME Frances Emma Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Hospital Records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Gastro Enteritis 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 20, 1959, to Mar 3, 1960, that I last saw the deceased alive on Mar 3, 1960, and that death occurred at 11:58 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L W Malin M.D.		ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED	
PHYSICIAN'S NAME (Type) L W Malin M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-5-1960	
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Bladensburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Riverdale Md		24a. REC'D BY REGISTRAR DATE MAR 7 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2076436XV6

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the Deputy Medical Examiner should be notified by the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

3721 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY in 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 7921 Marlboro Pike, Forestville, Md. d. STREET ADDRESS 7921 Marlboro Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GEORGE First Mann Middle WHITACRE Last		4. DATE OF DEATH March 31, 1960 Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1897 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George L. Whitacre		14. MOTHER'S MAIDEN NAME Anna M. Emory	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. 7921-Marlboro	
17. INFORMANT Madeline R. Whitacre		Address Forestville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart failure 442 X DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd EXAMINER'S NAME (Type) JAMES I. BOYD, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED April 1, 1960. Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr 4, 1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Switzland, Md.	
23. FUNERAL DIRECTOR Lee Funeral Home		24a. REC'D BY REGISTRAR APR 5 '60	
ADDRESS 300-4th St N.E. Wash D.C.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

DO NOT WRITE IN THESE SPACES

— 100 —

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3664 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03725

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Laurel			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4739 Baltimore Avenue				d. STREET ADDRESS 513 8th Street			
3. NAME OF DECEASED (Type or print) First Karen Middle Teresa Last White				4. DATE OF DEATH Month March Day 9, Year 19 60			
5. SEX Female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 7, 1959			
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR Months 5 Days Hours Min. 		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Ozie Shorter				
14. MOTHER'S MAIDEN NAME Evelyn White			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				
16. SOCIAL SECURITY NO.			17. INFORMANT Address Evelyn White; same address as #2.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] <div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input checked="" type="checkbox"/>. and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John T. Maloney M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John T. Maloney, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED March 9, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY			
Burial March 12/60		Recons Chapel		Bacon Tower Home Ground			
23. FUNERAL DIRECTOR'S SIGNATURE Ridgely Kelly 1200 Snowden Place							
ADDRESS							
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE MAR 16 '60			
Arthur L. Kraus							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2077266XV4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3780

CERTIFICATE OF DEATH

Reg. Dist. No.

03726

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY Washington, D.C. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland		c. LENGTH OF STAY IN lb 11 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 47X-3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nursing Home				d. STREET ADDRESS 312 N Street S.W.			
3. NAME OF DECEASED (Type or print) First Middle Last Mary B White				4. DATE OF DEATH Month Day Year March 23rd 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 2-1887		9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wash, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick White				14. MOTHER'S MAIDEN NAME Mary E. Healy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Frances F. White		2012 Address Ft. Davis St Wash, D.C. S4E.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 5 min 3 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Coroner notified and approved J22)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-22, 1959, to 3-23, 1960 that I last saw the deceased alive on 3-2-60, 19, and that death occurred at 12:30 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John B Fegan M.D. 2210 Nichols Ave S.E. Wash, D.C. 2210 Nichols Ave S.E. Wash, D.C.							
ACTUAL SIGNATURE John B Fegan		PHYSICIAN'S NAME (Type) JOHN B FEGAN M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-1960	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town, or county) (State) Wash, D.C.		23. FUNERAL DIRECTOR'S SIGNATURE Robert A Mattingly		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

3780

John D. Smith

White Male

Married

Age 65

3722 CERTIFICATE OF DEATH

Reg. Dist. No.

03727

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 14 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mattie Louise White				4. DATE OF DEATH March 1 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 31 July 1886	
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife		11. BIRTHPLACE (State or foreign country) River, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Adams				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mrs. Dorothy Walker				Address Mitchellville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 years 10+ years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus of recent origin						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 12-31 , 19 54 , to 3-1 , 19 60 , that I last saw the deceased alive on 2-29 , 19 60 , and that death occurred 6, 10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Waldo B. Moyers				ADDRESS (Street, city or town, state) 3503 Perry St.			
PHYSICIAN'S NAME (Type) Dr. Waldo Moyers				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-60		22c. NAME OF CEMETERY OR CREMATORY Trinity Episcopal		22d. LOCATION (City, town, or county) (State) Upper Marlboro Md	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers				ADDRESS Co. Riverdale Md		24a. REC'D BY REGISTRAR Arthur S. Kneale	
				DATE MAR 3 '60			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3325
1917
[Faint, mostly illegible text, possibly a letter or document, with some visible words like "Dear Sir", "Yours truly", and "Very respectfully"]

3723 CERTIFICATE OF DEATH

Reg. Dist. No.

03728

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS Box 512 Scaggsville Rd.			
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Robert Gray Whitehead				4. DATE OF DEATH Month March Day 8 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 Mar 1958	
9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months 11 Days 28		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Whitehead				14. MOTHER'S MAIDEN NAME Jane Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. INFORMANT Address William Whitehead, Laurel, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO acidosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes mellitus DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Mar 6, 1960 , to Mar 8, 1960 , that I last saw the deceased alive on Mar 8, 1960 , and that death occurred at 1,20AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John W. Perkins				ADDRESS (Street, city or town, state) 5301 Hamilton St. Hyattsville			
PHYSICIAN'S NAME (Type) John W. Perkins				DATE SIGNED 3/8/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 10, 1960		22c. NAME OF CEMETERY OR CREMATORY Emmanuel Cemetery		22d. LOCATION (City, town, or county) (State) Scaggsville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James R. Perkins				ADDRESS James R. Perkins		24a. REC'D BY REGISTRAR MAR 14 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

3724

CERTIFICATE OF DEATH

Reg. Dist. No.

03729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Hillside	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 1202 48th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Last Wishard		4. DATE OF DEATH Month March Day 9 Year 19 60		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 Jan 1895		9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Journey Harmon				14. MOTHER'S MAIDEN NAME Gertrude Burkett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Bernard Wishard		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Encephalomalacia DUE TO (b) Arteriosclerosis DUE TO (c) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 8 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 1 , 19 60 , to Mar. 9 , 19 60 that I last saw the deceased alive on Mar. 9 , 19 60 , and that death occurred at 1:10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry N. Carlton				ADDRESS (Street, city or town, state) 940-25th St, N.W., Wash DC DATE SIGNED 3-9-60			
PHYSICIAN'S NAME (Type) Dr. Harry N. Carlton, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 3/19/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co.		ADDRESS 517 11th St SE		24a. REC'D BY REGISTRAR MAR 14 60		24b. REGISTRAR'S SIGNATURE John A. Hanna	

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3725

CERTIFICATE OF DEATH

Reg. Dist. No.

03730

1. PLACE OF DEATH a. COUNTY Prince Georges				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 23 days				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Mt. Rainier				d. STREET ADDRESS 1405-31 st.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Prince Georges General				First Gale				Middle Young				Last Young				4. DATE OF DEATH Month March Day 10 Year 19 60																			
5. SEX Female				6. COLOR OR RACE White				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3-4-12				9. AGE (In years last birthday) 48 yrs.				10. IF UNDER 1 YEAR Months 48				11. IF UNDER 24 HRS. Days 48				12. IF UNDER 24 HRS. Hours 48				13. IF UNDER 24 HRS. Min. 48			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)								10b. KIND OF BUSINESS OR INDUSTRY								11. BIRTHPLACE (State or foreign country) Colorado								12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Charles E. Young												14. MOTHER'S MAIDEN NAME Nellie Paguter																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)								16. SOCIAL SECURITY NO. 269-01-3230								17. ADDRESS 2631 S. Wayne St., Arlington, Va																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 153.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Transverse Colon DUE TO (c) Unknown																INTERVAL BETWEEN ONSET AND DEATH Unknown																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19								20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from Feb. 14 19 60 to March 10 1960 , that I last saw the deceased alive on March 10 19 60 , and that death occurred at 2 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Arlington, Virginia DATE SIGNED Benjamin S. Miller																																			
ACTUAL SIGNATURE Benjamin S. Miller M.D.																																			
PHYSICIAN'S NAME (Type) Benjamin S. Miller																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL								22b. DATE THEREOF 3-14-60								22c. NAME OF CEMETERY OR CREMATORY Arlington National								22d. LOCATION (City, town, or county) (State) Arlington, Virginia											
23. FUNERAL DIRECTOR'S SIGNATURE Murphy J. Horne																24a. REC'D BY REGISTRAR DATE MAR 14 1960								24b. REGISTRAR'S SIGNATURE Charles E. Horne											

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Hollis Paster

Charles E. Jones

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